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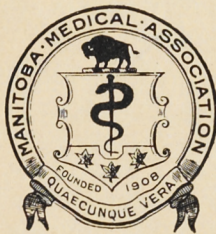
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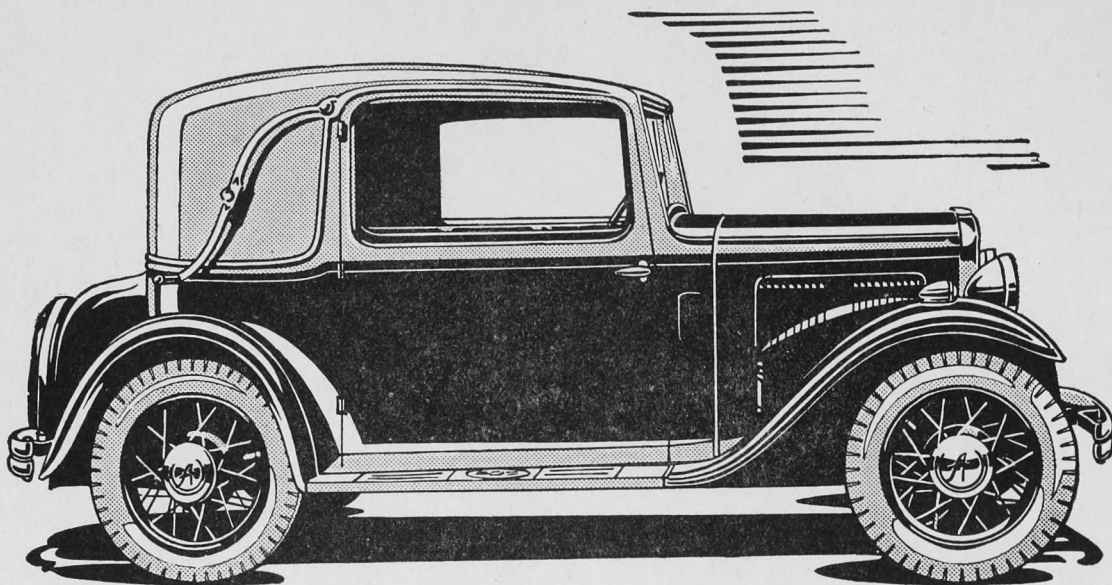


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## Clinical Section

### \* TRIGEMINAL NEURALGIA

By

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*"Of all the nerves, the trigeminus is most liable to neuralgia."* —OPPENHEIM.

#### Introduction.

Trigeminal neuralgia may be defined as a chronic progressive disease of which the sole primary symptom is pain limited to the area of distribution of the fifth cranial nerve. The condition was described as early as 1000 A.D. by the Arabian Avicenna. André in 1756 recognized the circumscription of the pain to the field of the trigeminal nerve and styled it "Tic Douloureux." This term, which is still in common usage, is unsatisfactory, as the tic or facial spasm is merely incidental to the disease itself.

To the above definition we may add that no other capacities of the trigeminal either sensory, motor or autonomic are directly involved, the affection being limited to the pain moiety only. Furthermore, no causal relationships have ever been established. The character of the pain is not that of a neuritis or a causalgia. There is no other pain like it in all human experience. We conclude, therefore, that trigeminal neuralgia is an entity.

By some authors the term trigeminal neuralgia is used to include not only a specific disease but also other pains in the face which may arise directly or indirectly from some definite focus. In the present instance we will exclude from the definition all those painful conditions for which a known cause may be assigned.

#### General Features.

It is a disease most commonly met with in middle life, the majority of cases occurring between the ages of 50 and 70 years. Typical examples have been described in younger people, but it is uncommonly rare before the age of 30. Females are affected slightly more commonly than males. The right side of the face is involved in 70% of instances. In less than 1% of cases is the pain bilateral, and the majority of these are diabetic. Any of the three main divisions of the nerve may be involved, but the symptoms invariably start in one division only. Furthermore, at the onset the pain is situated in the peripheral portion of the affected division, often being limited to one branch. The maxillary division is the commonest to be primarily affected; the mandibular is a close second, while the ophthalmic is a

rare third. Two or more divisions may become involved as the disease progresses, and when the ophthalmic is affected it is usually in a secondary role.

No general symptoms are associated except in statistical proportions. The general health of the patients keeps remarkably well considering the disability they suffer. Emaciation, decrepitude or confinement to bed seldom accompany the picture.

#### Symptomatology.

The outstanding symptom is pain.

"It is the most agonizing pain from which a patient may suffer."—PURVES-STEWART.

The symptoms, though varying in degree, are remarkably constant in character. In this respect they appear to vary only with the insight and ability of the patient to describe them. The most characteristic feature of the pain is its *paroxysmal nature*, which may be summed up as follows:

It consists of:

**Stabs**, lasting for *seconds*,  
recurring every few *minutes* in  
**Bouts**, lasting for *hours*,  
recurring every few *days* in  
**Attacks**, lasting for *weeks*,  
recurring after remissions of *months*.

To illustrate:

Mrs. B., now in her second attack, had her first attack one year ago. It lasted for five weeks. Twice a day during that time she suffered from bouts which lasted for from two to six hours. Her pain consisted of lightning-like stabs "like a red-hot corkscrew, which darts into my chin twenty times in half as many seconds, then goes away for anywhere from five minutes to half an hour."

Between the "darts of the red-hot corkscrew" the patient is free from pain, though a sense of discomfort (apprehension) may persist for some time. The stabs probably never keep up for more than two minutes without an appreciable intermission. This cycle of sharply demarcated pain and relief is pathognomonic of trigeminal neuralgia. It is present in every case.

The stabs may start spontaneously, but in some cases they are induced by minor disturbances such as a cold draught, masticatory movements or talking. Other types of extraneous interference such as firm pressure on the face are not likely to be so effective in initiating a paroxysm. For this reason patients often keep their faces at rest in a mask-like manner while a bout is in progress, refraining from eating or even speaking. It must be understood that this is an acquired voluntary phenomenon, in no way directly associated with the disease itself.

\*From the Faculty of Medicine, University of Manitoba.

The pain invariably starts at one constant point, radiating from there in a centripetal direction. The patient is always able to indicate this point.

Trigger zones, areas of local hypersensitivity, are present in the more advanced cases. These usually, but not always, correspond to the points at which the pain starts.

Several accessory phenomena may be associated with the attacks. They are probably all the result of the unparalleled severity of the pain. They are as follows:

1. Tonic spasm of the face on the affected side—the so-called tic.
2. Flushing of the corresponding half of the face.
3. Mydriasis.
4. Lachrymation.
5. Excessive flow of salivary and nasal secretion.

#### *Diagnosis.*

This is based entirely on clinical history, which, as previously mentioned, is remarkably constant in all cases. For this reason the diagnosis is usually easy, but one should always attempt to substantiate it by the method of exclusion.

The main clinical features are as follows:

1. The limitation of the pain to the sensory distribution of the trigeminal nerve.
2. The paroxysmal nature of the pain with intervals of comfort.
3. The absence of objective sensory motor or trophic disturbances.
4. The absence of any discoverable pathological lesion.

The exclusion of pains of reflex origin may necessitate a great deal of x-ray and surgical investigation. One point in particular is worthy of emphasis. Many cases are not diagnosed until after all the teeth have been removed. Later on, when a radical surgical procedure is carried out as a means of cure, it will be found that the anaesthesia so produced in the palate precludes the wearing of a dental plate. Hence, the mass extraction of teeth for presumably curative purposes should be very carefully considered if there is any possibility of the condition being due to trigeminal neuralgia.

#### *Differential Diagnosis.*

This has to be considered particularly in early cases and in those cases where the pain is felt on the inside instead of the outside of the face.

Two main groups may be described:

#### I. Pains in the distribution of other nerves:

##### (a) FACIAL HERPES:

The somatic sensory distribution of the facial includes a portion of the external

auditory canal. In such a case the pain is not peripheral at the onset and the typical vesicles of herpes will be found.

##### (b) GLOSSO-PHARYNGEAL NERVE:

This pain is felt in the region of the tonsil, base of the tongue and oro-pharynx. A trigger zone is often present on the tonsil. The spasms are initiated by yawning or swallowing and, again, the pain is not peripheral at the onset.

##### (c) SPHENO-PALATINE (Meckel's) GANGLION:

Lesions here give rise to a "lower half" headache, characterized by nocturnal attacks of pain in the eye, upper jaw, upper teeth or upper nasal fossae. Sneezing and rhinorrhœa are frequent accompaniments.

#### II. Other pains in the distribution of the trigeminal:

##### (a) HERPES OPHTHALMICA:

Corneal ulcers, loss of the corneal reflex and enlarged pre-auricular lymphatic glands are found.

##### (b) DIRECT IRRITATION:

The sensory root of the trigeminal may be irritated by an acoustic neuroma in the posterior cranial fossa. The Gasserian ganglion may be involved by an endothelioma in the middle cranial fossa. The peripheral divisions of the nerve may be irritated by sarcomata, etc., in the pterygoid region. In all such conditions there will be associated lesions in other nerves and in other structures.

##### (c) REFLEX NEURALGIAS:

This group appears to give the greatest trouble in arriving at a diagnosis. Sinus disease and dental lesions are common ailments which tend to produce reflex pains. But, even when such a lesion is responsible for the pain, it is usually definite, discernable and indictable beyond doubt.

#### *Actiology.*

The cause is unknown.

#### *Pathology.*

No constant pathological changes have been noted in any part of the trigeminal pathway. Minute vascular changes have occasionally been seen in the ganglion or its divisions, but these are probably local manifestations of the generalized circulatory changes commonly met with in people beyond middle age.

The most that one can say regarding the pathology is that the trouble lies somewhere between the Gasserian ganglion and the periphery, as section of the sensory root invariably abolishes the pain. In this respect does the disease differ from causalgia, where section of the posterior spinal roots does not always result in a cure.



*Progress.*

The condition may remain localized to one branch for years, but eventually tends to involve the whole of one division. Later, an adjoining division becomes affected and in rare instances the whole trigeminal area of one side is stricken.

The attacks tend to last longer and become more severe in intensity, while the intervals of freedom from pain gradually shorten. Yet, in spite of the relentless progress of the disease, the patient is entirely free of symptoms during the intermissions.

Very occasionally the trouble resolves spontaneously, in which case the patient may experience only one attack. While no figures are available as to the undoubted suicide rate amongst sufferers from this malady, Frazier states that in a personal experience of 1,317 cases he has never once met with a morphine addict.

*Treatment.*

Three methods only will be discussed, namely :

## I. INJECTION

## II. OPERATION

## III. TRI-CHLOR-ETHYLENE

I. In the first attack the usual remedies employed comprise the analgesics and morphine. These usually prove ineffectual in controlling the pain. In fact, this failure of medication to give relief is strong evidence in support of the diagnosis. It is, as a rule, unwise to attempt at this stage any form of treatment more radical than the injection of the branch involved. Since the pain is often limited to one peripheral branch only, an injection of novocaine or salt solution directly through the epilemmal sheath will give instantaneous and occasionally lasting relief.

When the case is seen in a second attack, or when the first attack is very severe and involves the whole of one division, one should attempt injection of the nerve close to the base of the skull. The injection this time should consist of alcohol. This will subvert all functions of the nerve, including pain, for about nine months.

Consequently, it is unwise to inject alcohol during the first attack. In the first place the patient may recover completely after one attack, in which case his nine months of anæsthesia would constitute a disability. Again, the second attack usually appears more than nine months after the first, so the injection would have to be repeated immediately—and the beneficial results of injection tend to diminish with repetition.

Several objections have been raised against the injection method of treatment. Injection of the ganglion itself is undoubtedly dangerous, but no serious damage can come from attacking one of the divisions outside the skull. Furthermore, Byrnes of Johns Hopkins claims to produce relief for as long as seven years by this method. Injection should always be carried out before undertaking an operation, for the following reasons:

- (a) It confirms the diagnosis.
- (b) Rarely it may cure the patient.
- (c) The pain of injection is not as bad as the pain of the disease.
- (d) It accustoms the patient to anæsthesia, and occasionally a patient will complain more of the anæsthesia than he did of the pain. In such an instance the noxious effect of injection, as opposed to operation, is not irremediable.

II. Operation is reserved for proven cases of an established nature, after all other methods have failed. The point of attack is the sensory root between the Gasserian ganglion and the pons. Here it is possible to preserve the motor root and at the same time obtain some degree of selectivity of anæsthesia, in that fibres from either the ophthalmic or mandibular divisions may be spared. Dandy goes so far as to state he can isolate and sever the pain fibres only, leaving intact the senses of touch, temperature and deep pressure. The mortality of operation averages about 1%. Its effects are absolute and permanent.

III. Tri-chlor-ethylene, an olefin derivative, has been used as a therapeutic agent since 1916. As the number of cases so treated is limited, no definite conclusions as to its efficacy can be drawn. The action of this drug was brought to the attention of the profession as the result of a series of cases of industrial poisoning in Germany. It was observed then to produce, amongst other things, a selective anæsthesia of the trigeminal areas.

It is administered by the inhalation of 20 to 25 drops on gauze three or four times daily for a month. Minor toxic effects may occur, but the literature up to the present indicates that 15% of cases are cured and 15% are relieved. These figures, though not impressive, strongly outweigh in value the effect of any other drug hitherto developed for this malady. Its place in the treatment of trigeminal neuralgia still remains to be ascertained.

## SOME MODERN TRENDS IN THE TREATMENT OF DIABETES

By

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### *Higher Carbohydrate Diets.*

The discovery of insulin has placed diabetes mellitus in the category of endocrine deficiency disorders similar to myxœdema or Addison's disease, and the term "hypo-insulinism" is rapidly replacing the older name of "diabetes." This conception of the disease has led to radical modifications of treatment. In pre-insulin days, the prin-

ciples of therapy as laid down by Allen consisted in restricting carbohydrate to a minimum, supplying enough protein to maintain nitrogenous equilibrium, and making up the caloric value of the diet with fat. Such a regime enabled the patient to drag out a semi-invalid existence, on a highly artificial and unpalatable diet, constantly undernourished, and faced with the peril of coma whenever he gave way to the irresistible craving for forbidden foodstuffs. With the discovery of insulin, some modifications of diet were made, but, generally speaking, the high-fat, low-carbohydrate type of diet was adhered to with the addition of minimal doses of insulin. During recent years, however, it has become more and more recognized that insulin therapy is really replacement therapy, exactly comparable to the administration of thyroid in myxœdema, and that it is possible to give a normal type of diet with moderately high carbohydrate values, without using large doses of insulin. In the study of higher carbohydrate diet it was determined that, if the fat were restricted markedly, the carbohydrate increased, the patient often required very little increase in insulin dosage to keep him sugar free. The objections to the high fat diets of former days are many. Such diets are abnormal and unpalatable, so that few diabetics can resist the temptation to "cheat." The state of malnutrition and slight acidosis, which they often induce, leads to a chronic feeling of ill-health. Insulin requirements are often paradoxically higher on such a diet than on a more normal balanced type of diet, and in any case, except for economic reasons, there is no reason why a patient should not take 40 units of insulin instead of 10, if he can lead a normal healthy life by so doing. Klotz and others have recently shown that there is a very definite relationship between hypercholesterolemia and the development of atheroma, and we know that patients on high fat diets are very prone to show constantly high values for blood cholesterol. Such a factor is of great importance today, when arteriosclerosis accounts for 47% of all deaths in diabetics.

#### *Treatment of Coma.*

Since the discovery of insulin, the mortality from coma has been reduced from 60% to about 10%. With proper management, this latter figure can be reduced even further.

The causes of coma may be expressed as follows:

1. Over-eating.
2. Increased metabolism from:
  - (a) Fever.
  - (b) Hyperthyroidism.

The diabetic must live on a lowered plane of metabolism, and every time he over-eats he risks coma. As Joslin has pointed out, the diabetic who takes insulin is well nourished and, when he omits his insulin, he can over-eat his own tissues, even if he curtails his food intake. The balance has

been upset and he may pass into coma. The commonest cause of coma today is infection, and every diabetic must learn to increase his insulin dosage whenever he develops an infection. Furthermore, he must be taught that nausea and vomiting are almost invariable symptoms of coma, and call for increased insulin, whether or not the meals are taken. There are many other causes of nausea and vomiting, such as appendicitis, acute infections, etc., but all such conditions will precipitate coma, and therefore must be considered by the patient as symptoms of impending acidosis.

In the diagnosis of coma, we must always remember that every patient with diabetes who is found unconscious is not in acidosis. He may be in insulin shock or uræmia. The onset of coma takes many hours or several days, whereas insulin shock comes on very quickly. Coma is usually heralded by nausea, vomiting, lassitude and thick speech. Both impending acidosis and hypoglycæmia may produce a state of mental confusion, ataxia and thick speech, identical with alcoholic intoxication. Abdominal pain, which may simulate some acute surgical condition, is not an infrequent symptom of diabetic acidosis. The clinical picture of coma is very characteristic; the respirations are long and sighing; the patient can be roused with great difficulty, if at all; the urine always contains sugar and ketone bodies; the tissues are shrunken and the eyeballs soft.

In treating diabetic coma, we are dealing with a marked dislocation of physiology, and we must visualize what is going on in the patient's body. When carbohydrate metabolism is not proceeding normally, the catabolism of fat stops at the stage of "B"—oxybutyric acid and aceto-acetic acid. These ketone bodies are very poisonous to the higher centres, causing dulling of consciousness, and finally coma, and furthermore they are acid in reaction and create a condition of acidosis. As these substances must be neutralized before excretion, they cause a depletion of the alkali reserves of the body. The treatment of ketosis consists in giving adequate amounts of insulin in order to restore normal carbohydrate metabolism, which in turn will enable fat catabolism to proceed normally. However, the fact which is often observed, that despite large doses of insulin coma patients frequently fail to rouse and may die of circulatory failure, would indicate that ketosis is not the sole factor at work in acidosis.

In impending coma, the blood sugar is very high and large amounts of sugar are being excreted from the kidneys. This excreted sugar carries with it tremendous quantities of water, and, unless the intake is correspondingly large, a marked degree of dehydration ensues. This dehydration is reflected graphically in the soft shrunken eyeball, the shrivelled tissues, the fact that the blood is greatly decreased in volume as shown by the high red cell count, the raised blood urea, the low blood pressure so constantly ob-



served in severe acidosis. Kidney function may fail, and circulatory failure end the picture if the blood volume and tissue fluids are not restored to normal.

We may therefore postulate two great aims in the treatment of diabetic coma:

1. Restoration of normal carbohydrate combustion by the administration of large doses of insulin covered, if necessary, by glucose.
2. Restoration of normal blood volume by the giving of large quantities of fluids, intravenously, by mouth or by proctoclysis.

No rule of thumb can be laid down for the treatment of coma, as each patient presents an individual problem, which must be solved by an intelligent evaluation of the factors which have brought him to such a perilous state. If one can visualize exactly what physiological changes are taking place in the patient's body, one can proceed with the energy and despatch which form the secrets of successful treatment. Once the patient has recovered from acidosis, one must then proceed to make an exhaustive search for the underlying cause of his coma. It is useless to revive a patient from diabetic acidosis only to have him die from general peritonitis, or pneumonia, but it is equally hazardous to attempt surgical or medical measures for the underlying condition when the patient is deeply comatose from an uncontrolled acidosis.

## CASE REPORTS

### \* THREE CASES OF TOXÆMIA OF PREGNANCY

By

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In the autumn of 1933 the obstetrical department of St. Boniface hospital admitted to its wards five cases of severe pregnancy toxæmia within the space of thirteen days. Of these three proved to be of special interest and the following is a short summary of their case histories.

#### CASE 1.—Eclampsia.

Mrs. B. Age 20. Grav. 1 – Para 0, L.N.M.P.  
Dec. 1, 1932 – E.D. Sept. 8, 1933. Admitted  
Aug. 27, 1933.

#### *Entrance Complaint.*

Patient brought to hospital from out of town complaining of:

1. Headache—duration one week.
2. Epigastric pain—duration one week.
3. Vomiting—duration one week.

\*Reported to St. Boniface Hospital Clinical Meeting  
February 8, 1934.

#### *History of Present Pregnancy.*

First trimester—occasional vomiting.  
Second “ —occasional vomiting.  
Third “ —slight oedema of ankles, easily tired, urine examined one week prior to admission was normal.

*Previous Illnesses:* None of importance.

#### *Examination.*

Patient was very restless and irritable. Abdominal examination revealed a full term pregnancy. Fœtal heart sounds were distinctly audible. The head was not engaged and patient was not in labour.

There was no oedema.

Blood pressure 156/116.

Fundi—Negative (blurred vision complained of).

—Urine – albumen marked, also a few granular and hyaline casts.

Blood urea N. 13 mgm. per 100 cc.

#### *Treatment and Progress.*

Immediately upon admission at 9 a.m. the patient was given 20 cc. of 10% solution of magnesium sulphate intravenously, and morphine grs.  $\frac{1}{4}$  hypodermically.

At 10.15 a.m. 95 cc. of blood was withdrawn by venesection and 200 cc. of 10% solution of Glucose given into the circulation. Headache was by this time greatly relieved. She was then given an ounce of castor oil by mouth.

At 1.30 p.m. the blood pressure was down to 137/94.

At 2.30 labour pains commenced, and she vomited. Morphine grs.  $\frac{1}{4}$  was again given. At 4 p.m. the patient again vomited and was given 20 c.c. of 10% solution of Mag. Sulph. intravenously.

During the afternoon labour had progressed favorably and at 6 p.m. the membranes ruptured. By this time the blood pressure had reached the level of 170/116 and at this time intravenous glucose 200 cc. of 10% solution was again given.

At 8 p.m. the blood pressure was 158/116, and at 8.07 she had a violent convulsion lasting for a period of three minutes. At 8.45 a second convulsion occurred which lasted for 3 minutes.

At this time 12 hours after admission, the patient was delivered instrumentally of a living child weighing 6-lbs.

Following delivery intravenous glucose was again given (250 cc. of 10% solution) and it appeared that all was well, the blood pressure was 140/96. At midnight she was soundly sleeping.

At 2 a.m. she was suddenly seized with another convulsion which lasted for 3 minutes. Morphine and intravenous mag. sulph. (20 cc. of 10%) were again given.

Following this the patient was given colonic irrigation, intravenous glucose, and the occasional dose of morphine.

The blood pressure slowly receded, and on Sept. 11 was 128/75. The urine contained a faint trace of albumen and the specific gravity was 1022.

Mother and child discharged Sept. 11, 1933.

#### **CASE 2.—Pre-Eclampsia (with muscular twitching).**

Mrs. G. Age 20. Gravida 1, Para 0; L.N.-M.P. Dec. 24, 1932. E.D. Oct. 1, 1933. Admitted Sept. 9, 1933.

##### *Entrance Complaint.*

1. Pain in back—12 hours.
2. Oedema of ankles—4 months.
3. Visual disturbances—2 days.

##### *History of Present Pregnancy.*

This young woman walked into the hospital seeking admission on account of severe pain in the back. She was approximately 7 months pregnant, although the menstrual history indicated her pregnancy to be past the 8th month.

Further history revealed that she had recently been complaining of frequent frontal headache and for the past month nocturia had become a symptom. There had been moderate oedema of the ankles for 4 mos. Two days previously she commenced to have visual disturbances evidenced by "specks" before the eyes.

##### *Examination.*

On admission the blood pressure was 204/145. The foetus was alive and the patient was not in labour. The level of the fundus was 2" above the umbilicus. The urine contained marked albumen, and a few hyaline casts.

##### *Treatment and Progress.*

Shortly after admission when the diagnosis of pre-eclamptic toxæmia had been established, this patient was given morphine, and this followed by colonic irrigation; after which 125 cc. of blood was withdrawn by venesection; and this replaced by the administration of 300 cc. of 10% glucose solution.

Twelve hours after admission the blood pressure had fallen to 184/142 and the patient was feeling well. A few hours later, however, her condition suddenly changed—she vomited, complained of "specks" before eyes, and muscular twitching was observed—particularly in the face. The blood pressure was now 210/155. Morphine grs.  $\frac{1}{6}$  was given, and intravenous glucose repeated (300 cc. of 10% solution). A few hours later she was given mag. sulph. intravenously (20 cc. 10%) mag. sulph. by mouth. Within the next twelve hours she was given two doses of morphine grs.  $\frac{1}{4}$ , and two intravenous infusions of glucose solution as well as colonic irrigation, and at the end of this time the blood pressure had fallen to 164/124.

Despite this rather intensive treatment the blood pressure again mounted. Concentrated glucose solution (50 cc. of 50%) given intravenously failed to have beneficial effect. The blood pressure at this time was 194/150.

On the fourth day after admission labour was induced by means of inserting a rectal tube into the uterus. Six hours later she was delivered of a minute living infant weighing 2 pounds and 12 ounces.

Following delivery active treatment was continued. The blood pressure rapidly fell, and on the 19th day post partum the patient was discharged with a blood pressure of 124/88 and the urine showing a faint trace of albumen.

The baby was discharged 2 months later weighing 5 pounds.

#### **CASE 3.—Eclampsia.**

Mrs. J. Age 40. Grav. IX, Para VII. Pregnancy in 7th month. Admitted Sept. 10, 1933.

This woman was admitted to the medical wards of the hospital. She was semi-conscious, and apparently in a state of shock and practically moribund. The history obtained from her husband was that she had been vomiting very frequently for the previous 24 hours, and for 3 days had had some headache and swelling of the ankles. She had two convulsions prior to admission, and was given morphine by her doctor prior to being brought 100 miles by motor to the hospital. Foetal movements had not been felt by her for 5 days, and on admission the foetal heart was silent. Before this time this pregnancy had been normal.

##### *Previous Pregnancies.*

One miscarriage due to accident—all other pregnancies and deliveries were uneventful.

##### *Treatment and Progress.*

As soon as this case was transferred to the Obstetrical Service she was given morphine grs.  $\frac{1}{4}$  and this was followed by 20 cc. of 10% solution of magnesium sulphate intravenously. The blood pressure was 138/80 and the urine contained marked albumen, and a few hyaline and granular casts.

Subsequent treatment in this case consisted in the free administration of concentrated glucose solution (50 cc. of 50% given at a time) and magnesium sulphate by mouth. When the patient had recovered sufficiently labour was induced by oral administration of quinine and castor oil. The blood pressure had reached its peak at 158/96.

Thirty-six hours after admission labour began, and after labour of 8 hours' duration a macerated foetus was delivered.

Early post partum treatment consisted chiefly of the administration of intravenous glucose in



25% solution; 100 cc. being given on three occasions. The blood pressure remained elevated for a few days, but on the 17th day after admission was 124/74. The urine had completely cleared, and the transformation effected in the few days from a patient moribund to a normal healthy woman was indeed spectacular.

#### SUMMARY OF CASES.

These cases illustrate some important points in the practice of midwifery. **FIRST** that the symptoms of eclampsia may be dramatic and sudden in onset and therefore pre-natal supervision cannot be too rigid or thorough during the last trimester. In Case 1 the urine examined by her doctor one week previous to admission was normal. **SECOND** that examination of the blood, and other special examinations reveal little abnormality in eclampsia. **THIRD** no disease can be treated on scientific grounds without definite knowledge of its aetiology, and this, unfortunately, has been our position with respect to the toxæmias of pregnancy. Here we are treating symptoms as they arise, and are at the same time attempting to anticipate symptoms and treat them before they arise. Cæsarian section is not recommended by teachers of Midwifery. Treatment has in all these cases been conservative, but energetic, and may be summarized as follows:

- 1.—*Sedation*—obtained by morphine liberally given (grs.  $\frac{1}{4}$  may be given with every fit till 3 grs. in 24 hrs. if necessary).
- 2.—*Venesection*—where indicated.
- 3.—*Intravenous solution of Glucose*. This replaces the depleted store of food, spares the liver, draws fluid from the tissues, stimulates diuresis, lessens cerebral oedema, thereby aiding in controlling the severity and number of convulsions.
- 4.—*Fluid balance*. Intake not exceeding output, 40-oz. fluid sufficient per day.
- 5.—*Colonic irrigation*.
- 6.—*No salt*.
- 7.—*Conservative induction*, where warranted.
- 8.—*Intravenous mag. sulph.* 20 cc. 10% O.H. ii may be given until convulsions are controlled.

—An excess of magnesium ions depresses the irritability of muscle and nerve. Also the magnesium opposes the stimulant action of the Na (sodium) ion which is present in excess in the tissues in these cases. It also replaces the calcium ion. The  $\text{So}_4$  ion acts as a diuretic.

#### OBITUARY

Dr. William Black died in Victoria Hospital on April 3rd, at the age of 57, following an attack of cerebral hæmorrhage. He was born in Bruce County, Ontario, but his parents moved to Morden, Manitoba, shortly afterwards. Graduating from Manitoba Medical College in 1904, he was for some time medical superintendent for construction for the Canadian Pacific Railway,

and later served with Foley, Welsh and Stewart, contractors, before entering private practice. During the War he served as a medical officer with a Winnipeg regiment. He was greatly interested in sport, and was open hearted and generous. He is survived by two sons. Dr. Black was, for many years, a member of the Manitoba Medical Association.

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## Medical Library University of Manitoba

A summary of the contents of some of the journals available for practitioners, submitted by the Faculty of Medicine of the University of Manitoba. Compiled by T. E. HOLLAND, B.Sc., M.D. (Man.), F.R.C.S. (Edin.).

### THE PRACTITIONER—February, 1934.

This issue of *The Practitioner* is devoted to the subject of "Physical Treatment in General Practice." The following articles are well worth reading:

- "Methods of Physical Treatment: Introduction"—by Sir Humphrey Rolleston.
- "Ultra-Violet Radiation in the Treatment of Disease"—by Sir Robert Stanton Wood, F.R.C.P.
- "The Manipulative Treatment of Disease"—by James Mennell, M.A., M.D.
- "Massage in General Practice"—by L. D. Bailey, M.R.C.S., L.R.C.P.
- "The Action and Uses of the Diathermic Current"—by E. P. Cumberbatch, F.R.C.P.
- "Physical Methods in Skin Diseases in General Practice"—by W. J. O'Donovan, M.D., M.R.C.P.
- "Physical Treatment in Nervous and Mental Diseases"—by R. G. Gordon, M.D., F.R.C.P. (E.)
- "Physical Methods in the Treatment of Rheumatism, Arthritis and Fibrositis"—by Chas. W. Buckley, M.D., F.R.C.P.
- "Physical Methods in the Treatment of Injuries"—by W. Eldon Tucker, F.R.C.S.

### THE PRACTITIONER—March, 1934.

This number contains a symposium on "Sterility and Its Treatment," in which are the following articles:

- "On Infertile Marriage"—by Eardley Holland, M.D., F.R.C.P., F.R.C.S., F.C.O.G.
- "Endocrine Aspects of Sterility"—by Emil Novak, M.D., F.A.C.S.
- "The Modern Approach to the Problem of Human Sterility"—by Samuel R. Meaker, M.D., F.C.O.G.
- "Sterility in the Female"—by R. A. Gibbons, M.D., F.R.C.P.
- "Sterility in the Male"—by Kenneth M. Walker, F.R.C.S.

The following articles are also included in this issue:

- "Menstruation and Its Relation to Disease"—by W. C. Nixon, M.D., F.R.C.S.
- "Anæsthesia in Labour: A Review of Modern Progress"—by F. B. Parsons, M.R.C.P.

### THE CANADIAN PUBLIC HEALTH JOURNAL March, 1934.

- "A Five-Year Survey of Maternal Mortality in Manitoba, 1928-32"—by F. W. Jackson, D.P.H.; R. D. Defries, D.P.H.; A. H. Sellers, D.P.H.

- "Diagnosis of Early Thoracic Tuberculosis in Children"—by H. I. Kinsey, M.B., Toronto.

### THE LANCET—January 6th, 1934.

- "Poisoning by Barbitone and Allied Drugs"—by Sir J. Purves Stuart and Sir William Willecox.

### THE LANCET—March 31st, 1934.

- "Carcinoma of the Prostate"—by E. G. Muir, F.R.C.S.

- "Lower Segment Cæsarean Section as a Routine"—by K. V. Bailey, M.R.C.P.

### THE CANADIAN MEDICAL ASSOCIATION JOURNAL March, 1934.

- "The Outlook for Overcoming Pneumonia"—by Rufus Cole, M.D., Rockefeller Institute, New York.

- "Clinical Studies with the Urea-Clearance Test"—by Lennox Bell, M.R.C.P.; C. R. Gilmour, F.R.C.P. (C.); A. T. Cameron, D.Sc., F.R.S.C.

- "Pulmonary Embolism"—by T. H. Belt, Toronto.

- "Bilirubin Formation and the Reticulo-Endothelial System: The Kupffer Cells and Their Relation to the Reticulo-Endothelial System"—by R. Gottlieb, M.D., Montreal.

- "Idiopathic Spontaneous Pneumothorax in Apparently Healthy Adults"—by C. H. Vrooman, M.D., F.R.C.P. (C.), Vancouver.

- "Angina Pectoris: A Clinical Classification"—by D. M. Baltzan, M.D., F.R.C.P. (C.), Saskatoon.

- "The Early Diagnosis of Carcinoma of the Lung"—by J. C. Meakins, M.D., Montreal.

- "Ménieres Disease, with Report of a Case"—by J. E. Whitworth, M.D., Montreal.

- "Poisoning with the Derivatives of Barbituric Acid"—(Editorial).

### THE NEW ENGLAND JOURNAL OF MEDICINE March 29th, 1934.

- "Examination of the Stomach by Means of a Flexible Gastroscope"—A preliminary report, by Edward B. Benedict.

- "The Neoplastic Factor in Chronic Ulcerative Colitis"—by John C. M. Brust and J. Arnold Bayen, Rochester.

- "Neoplasms Originating in the Ischiorectal Fossa, with Particular Reference to Sarcomata"—by W. M. Shedden, Boston.

### JOURNAL OF AMERICAN MEDICAL ASSOCIATION February 10th, 1934.

- "Gangrene due to Thrombo-Angiitis Obliterans"—by Saul S. Samuels, M.D., New York.

—Case histories are given of twelve patients suffering with this disease, nine of whom were Jewish. Treatment consists of (1) rest in bed (2) prohibition of smoking (3) intravenous hypertonic saline injections and (4) cleanliness of ulcerated or gangrenous areas. The author condemns the sympathectomy and ganglionectomy operations and attributes any improvement observed after them to the post-operative rest in bed.



## Editorial and Special Articles

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### HOSPITAL SECTION OF THE WINNIPEG MEDICAL SOCIETY

For some time it has been suggested that there was need for some organization which could represent the honorary attending staffs of the various hospitals, where public wards or out-patient departments are maintained. The honorary attending staff of each hospital has had its own organization, but there has been no body which linked these various groups, either to each other or to the existing medical societies. In the past few months, steps have been taken to remedy this deficiency, and the work which has been done is of very great importance to the medical profession and deserves the close attention of every doctor. Already one very important recommendation has been brought forward, *namely*, that all the hospitals of Greater Winnipeg adopt the system instituted at the Winnipeg General Hospital and form the out-patient department into a consulting service and require that every patient reporting for examination present a letter from his own doctor.

In addition it has been suggested that this plan might be extended by having the honorary attending staffs of all the Manitoba hospitals brought into relation with their respective district societies. At a general meeting of the med-

### MANITOBA MEDICAL ASSOCIATION

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DR. G. W. ROGERS, *First Vice-President*.....Dauphin  
DR. W. W. MUSGROVE, *Second Vice-President*.....Winnipeg  
DR. F. W. JACKSON, *Honorary Secretary*.....Winnipeg  
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DR. A. F. MENZIES, *Retiring President*.....Morden

#### MEMBERS ELECTED AT LARGE

DR. W. J. ELLIOTT.....Brandon (Term Expires 1934)  
DR. A. G. MEINDL.....Winnipeg (Term Expires 1934)  
DR. E. D. HUDSON.....Hamiota (Term Expires 1935)  
DR. J. S. MCINNES.....Winnipeg (Term Expires 1935)  
DR. C. W. WIEBE.....Winkler (Term Expires 1936)  
DR. F. A. BENNER.....Winnipeg (Term Expires 1936)

#### REPRESENTATIVES OF DISTRICT SOCIETIES

*Central District*.....DR. W. H. CLARK  
*Southern District*.....DR. E. K. CUNNINGHAM  
*Brandon and District*.....DR. T. A. PINCOCK  
*North-Western District*.....DR. R. F. YULE  
*Winnipeg Medical*.....DR. R. RENNIE SWAN  
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#### REPRESENTATIVE ON C.M.A. EXECUTIVE COMMITTEE

DR. J. D. ADAMSON.....Winnipeg

ical profession of Greater Winnipeg on February 28th, 1934, the following report was presented:—

The formation of a Hospital Section of the Winnipeg Medical Society was recommended at a general meeting of the medical profession held June 6th, 1933, and Dr. F. D. McKenty was appointed Chairman of a committee to carry out the organization. The first step toward implementing this recommendation was taken by the issue of the following circular letter to the Chairman of the staff organization of the following hospitals: Winnipeg General, St. Boniface, Grace, Misericordia, Children's, St. Joseph's, Mount Carmel Clinic and Victoria:—

November 1st, 1933.

Dear Doctor:

"At a general meeting of the Honorary Hospital Staffs of Greater Winnipeg, held June 6th, 1933, the following resolution was unanimously adopted:

'THAT steps be taken to organize all Honorary Attending Staffs of Greater Winnipeg Hospitals and Clinics into a hospital section of the Winnipeg Medical Society.'

"The undersigned was named Chairman of a committee to implement the above resolution.

"The purpose of the proposal is to complete the formal organization of the Winnipeg Medical

Society by linking up with it the staffs of the various hospitals. Under present conditions, these are independent organizations, which have no definite relationship or sustained contact with the Winnipeg Medical Society, or with each other. Problems which are common to all must either be worked out separately, or efforts at concerted action must wait upon the formal action of staff meetings, or negotiation through hastily appointed and often ill-prepared delegations. This leads to delayed, uncertain or incoherent action.

"It is hoped that, by forming some organic relation, a direct avenue of communication may be opened, and a forum provided where such problems as are common to all may be considered, with the aim of reaching a uniform solution.

"Such being the purpose of the organization, the structure may be relatively simple. It is suggested that the membership of the hospital section be composed of the members of all organized honorary hospital staffs; that the section should have an Executive body made up of the President and Secretary of each staff, and that this Executive should hold a meeting and choose a Chairman and Secretary from their number, and adopt any constitution or rules deemed necessary. After notification of such action, the Winnipeg Medical Society would thereupon install the Secretary of the hospital section as a member of the Executive. It is further suggested, in the matter of meetings of the Executive of the hospital section, that there should be one annual organization meeting, and that others should be held whenever required, at the call of any two members of the Executive.

"If you approve of these suggestions as a method of procedure, kindly have them authorized by the staff of your hospital, and notification sent to the undersigned. A brief meeting should then be all that is necessary to complete the arrangements. If, on the other hand, you prefer a different way of proceeding, a meeting of the Presidents of the hospital staffs can be arranged to decide upon the best."

(Signed) F. D. McKENTY,  
*Chairman of Committee.*

The response to this letter was favorable from the majority of the staffs notified, but in some instances the letters failed to reach their intended destination, and in others the information contained in the letter as to the aims of the organization was not considered sufficiently clear.

No further action was taken until the Special Relief Committee, in a resolution passed on February 3rd, 1934, recommended that the matter be proceeded with without further delay. The organization committee then issued a circular letter to the Chairman of the Honorary Attending Staff of each institution already mentioned, requesting that the Chairman and Secretary of the staff attend a meeting on February 9th, 1934. This meeting was inconclusive, owing to a misinterpretation of the term "honorary staff." How-

ever, it was agreed by those present to obtain the opinion of their respective honorary staffs on two questions, namely:

1. As to the willingness of the staff to co-operate with the Hospital Section as outlined in circular letter of November 1st, 1933.

2. The reaction of the staff as to the advisability of securing the co-operation of their hospital management in the uniform administration of all free clinic work, in accordance with the plan now adopted by the Winnipeg General Hospital.

The next meeting was held in the Medical Arts Club Rooms on Wednesday, February 14th, 1934, with the following representations:

Winnipeg General Hospital	Drs. C. R. Gilmour and C. W. Burns
St. Boniface Hospital	Drs. L. D. Collin and J. C. Hossack
Children's Hospital	Drs. Bruce Chown and H. E. Popham
Grace Hospital	Drs. F. A. Benner and A. Leishman
St. Joseph's Hospital	Drs. W. E. R. Coad and G. Novak
Misericordia Hospital	Drs. F. D. McKenty and H. M. Murdoff
Victoria Hospital	Drs. G. C. Dodds and J. S. Gardner
Mount Carmel Clinic	Drs. A. P. Guttmann and H. Hershfield

Dr. F. D. McKenty, who called the meeting, occupied the chair, and asked Dr. W. E. R. Coad to act as Secretary pro tem.

The Chairman called the meeting to order and outlined the aims of the proposed organization of a Hospital Section in connection with the Winnipeg Medical Society as follows:

"The proposal that we have to consider is the linking up of the various organized hospital staffs in some way so that they will be in continuous relation and easy communication with each other and with the central medical organization.

"The idea has, after consideration, received the endorsement of both the Executive and Committee on Medical Relief, and it is in accordance with the definite instruction of the latter body that this meeting has been called. I wish to make it perfectly clear, both what is involved in this proposal, and what is not. To do so, I must first answer a question I have been asked: 'Why more organization? Is there not some danger of over-doing it, and crystallizing something that should be resilient?' There is force in such criticism, and it must be considered. But one does not need, at this stage, to argue the question of some organization versus none at all. The real question is: 'How much organization should we have?'

"Organization must always follow and depend upon the function it has to perform. We should have just enough to enable us to accomplish harmoniously our common purpose or purposes. More than that would be over-organization, and worse than useless. We represent about half a dozen separate medical organizations, with no relation to each other or to any central body. We have



no existing facilities for acting together, or through any centralized body, or of securing the co-operation of such a body if it should be required. All such action must wait upon special arrangements that are tedious and troublesome. Through lack of prompt action, minor matters that might be adjusted may be allowed to grow into major issues, and opportunities for useful co-operation may be allowed to lapse. Function is thus hampered through insufficient organization. The proposed Hospital Section would seem a simple and sufficient organization to meet this need. It should be a body for liaison and consultation mainly, for solving common problems by discussion, and settling in advance any divergence of interest by reasonable compromise.

"It is *not* contemplated that the Hospital Section should assume mandatory control over any of the constituent groups, or concern itself in matters that interest a single staff only, unless it is asked to do so. Its function is to promote voluntary co-operation for the common welfare."

A general discussion of the subject followed. The two members from the Winnipeg General Hospital, Drs. Gilmour and Burns, notified the meeting that they were unable to commit their staff to any action, as they had not yet been instructed to do so, but they shared in the discussion and undertook to present the matter further to the honorary staff.

Dr. Collin, for St. Boniface Hospital, notified the meeting that the staff had not yet considered the question of the out-patient clinic, but would do so at an early date.

The discussion being favorable to the proposal, it was moved by Dr. Bruce Chown, seconded by Dr. H. M. Murdoff: That a Hospital Section of the Winnipeg Medical Society, as outlined, be formed —Carried unanimously.

The meeting then proceeded with the usual steps of organization.

#### **Name.**

It was moved by Dr. A. Leishman, seconded by Dr. G. C. Dodds: That the name of this Section shall be The Hospital Section of the Winnipeg Medical Society. —Carried.

#### **Purpose.**

It was moved by Dr. F. A. Benner, seconded by Dr. W. E. R. Coad: That the purpose of the Section shall be as follows: "The aim of this organization is to facilitate the co-operation of its constituent bodies by establishing a quick and easy way of communication and consultation. It is to deal with the problems that concern all in common. It should seek, by full and patient discussion, to develop a unanimous opinion on all problems presented to it, and to reconcile diverging views by timely and reasonable compromise. It is not contemplated that this Hospital Section shall assume mandatory control over any of its constituent groups, or that it shall interest itself

in matters that concern only a single staff. Its function is to promote voluntary co-operation for common welfare." —Carried.

#### **Membership.**

It was moved by Dr. G. C. Dodds, seconded by Dr. A. L. Shubin: That the membership of the Hospital Section shall consist of all members of the Hospital's Honorary Staffs who are in good standing in the Winnipeg Medical Society. —Carried.

#### **Council.**

It was moved by Dr. F. A. Benner, seconded by Dr. G. Novak: That the Council of the Hospital Section shall be composed of the President and Secretary of each Honorary Hospital Staff ex-officio; and that the officers of this Hospital Section shall be President and Secretary, to be elected by the Council from their members at the organization meeting, and thereafter at each Annual Meeting. —Carried.

#### **Election of Officers.**

The meeting then proceeded to appoint a Chairman and Secretary.

It was moved by Dr. F. A. Benner, seconded by Dr. G. C. Dodds: That Dr. F. D. McKenty be Chairman. —Carried.

It was moved by Dr. Bruce Chown, seconded by Dr. L. D. Collin: That Dr. W. E. R. Coad be Secretary. —Carried.

#### **Meetings.**

It was moved by Dr. A. Leishman, seconded by Dr. H. E. Popham: That meetings shall be one annually, to be held within a month of the Annual Meeting of the Winnipeg Medical Society, all members of the Council to be duly notified in writing; and the other meetings to be called by the officers of this Council when required, or when requested by any two members of the Council. —Carried.

#### **Out-Patient Administration.**

After completion of organization, the question of out-patient administration was opened for discussion. The members from the Children's Hospital pointed out that the application of such a policy in their out-patient department was of no advantage to the institution, and in fact, they were unable to see why it should be adopted in any hospital. It was agreed by the meeting, that, under the circumstances, the Children's Hospital was in a special position, but, as all the other representatives were in favor of the method adopted at the Winnipeg General Hospital, it was moved by Dr. F. A. Benner, seconded by Dr. J. S. Gardner: That the staffs of the various hospitals represented at the meeting (with the exception of the Children's Hospital) should approach their respective hospital administrations with the aim of securing their consent and co-operation in the adoption of the method of out-patient manage-

ment now applied at the Winnipeg General Hospital, and thus make the system as far as possible uniform throughout Greater Winnipeg.

—Carried unanimously.

The meeting adjourned.

(Signed) F. D. McKENTY,  
*Chairman.*

W. E. R. COAD,  
*Secretary.*

## ORGANIZATION OF THE MEDICAL PROFESSION

In the minutes of the meeting of the Executive of the Manitoba Medical Association there is reference to the plan for organization proposed by the Special Relief Committee. This plan was accepted by the Executive of the Association. The principal step taken has been the establishment of an Advisory Council constituted as outlined in the minutes, and the appointment of a chairman of a Committee on Sociology. In the consideration of any problem the opinions of the organized medical societies, the Medical Faculty, the College of Physicians and Surgeons, and the Department of Health and Public Welfare will all be available. In addition, where the question under consideration refers to one particular locality, the local district medical society, the local medical officer of health, and the honorary attending staffs of the voluntary hospitals will be represented, and other bodies may be represented if considered advisable. Questions of general policy will be referred to this Advisory Council. Executive action will rest with the Manitoba Medical Association and the implementing of any contemplated action may be entrusted to the chairman of the Committee on Sociology.

The importance of the step which has been taken cannot be over estimated. It will mean that questions referring to the health of the community, the provision of medical services, the relations of the medical profession with the public and with governmental bodies will in future receive consideration from every possible point of view, and when action is advised or taken such action will reflect the considered opinion of all the members of the medical profession and all the various organized medical bodies. In addition, the organization will also ensure that any action contemplated by any of the statutory medical bodies, such as the teaching faculty or the Department of Health and Public Welfare, will receive the consideration and be subject to the advice of the whole medical profession.

Had such an organization been in existence, some of the mistakes which have been made in the past resulting in waste of effort and unnecessary expense to the taxpayer might have been avoided.

It is now obvious that the time is long since past in which the whole duty of the medical pro-

fession could be discharged by the effort of individuals. Much can now be effected only through the agency of organized medical bodies and some of this has been defaulted through defect of public spirit and inadequate organization. The machinery now provided should facilitate and encourage movements of this character but nothing but an enlightened public spirit will initiate them and this will require a sense of both the responsibilities and the privileges of the medical profession.  
C. W. MacC.

## THE MANITOBA MEDICAL COLLEGE



THE Manitoba Medical College is celebrating its fiftieth anniversary, although the application for the charter to form the College was presented to the local legislature in 1883, and the first lectures were given in November of

that year. From the first, the work of the College has been confined to teaching and the degrees have been conferred by the University of Manitoba. The Manitoba Medical College was financed by voluntary donations from the members of the medical profession and students' fees, and the lecturers in clinical subjects gave their services free. The University of Manitoba helped by furnishing, through full time professors, lectures in such subjects as chemistry, zoology, physiology and pathology.

During the Great War, in addition to members who enlisted in various units of the C.E.F. and the Imperial Forces, five field ambulances and two casualty clearing stations were raised in Winnipeg and officered largely by members of the Faculty of the Manitoba Medical College or graduates of the College, while many students served in the ranks of these units. Number 4 Casualty Clearing Station was raised by the Manitoba Medical College—the college had offered to raise any unit required and the Department of Militia asked them to form a C.C.S.

In 1918-19 the Manitoba Medical College made a gift of its property and equipment to the University of Manitoba "on condition that the University establish a Faculty of Medicine and carry on the work of medical education in an efficient manner."

New buildings have been gradually added from time to time, and shortly after the War an endowment fund was contributed to the Medical Faculty by John D. Rockefeller, the American philanthropist, through the Rockefeller Foundation.

When it was first founded, the Manitoba Medical School was intended to furnish a course in medicine to men in Western Canada. During the period of rapid increase of population in Western Canada, graduates of the Manitoba Medical College took their place beside the graduates of the older Eastern Canadian Schools in this pioneer country.



Since the establishment of the Dominion Council examinations, the results have shown that graduates from this school stand higher than the average among graduates taking these examinations. In most years since the War, the proportion of successes among graduates of the Manitoba Medical College in the Dominion Council examinations has been either highest or second highest among the various Universities in Canada. It is probable that, in the years since the Great War, a higher proportion of graduates of the Manitoba Medical College have done post-graduate work in the Old Country than is the case in any Canadian University. There are already several hospitals in London and the provinces where graduates of the Manitoba Medical College are well and favourably known. Each year since the War a certain number of graduates have passed the examinations and been elected to membership or fellowship in the Royal Colleges.

It would not seem unreasonable to conclude that, although the buildings of the Faculty of Medicine of the University of Manitoba may present a drab contrast to the architectural eminence of the homes of some other Canadian Medical Schools, the standard of academic qualification demanded of its students is consistently high and second to none in the Dominion of Canada. During the past two years the general as opposed to the academic standards for admission have been made more stringent, and the application of each prospective student is reviewed by a committee on admission before his application is accepted, and he is allowed to proceed with his first year work. A certain number of students are eliminated at the end of the first half term, and the examination mortality at the end of the first year is thirty-five to forty per cent.

The University, also since the War, has con-

ferred the post-graduate degree of Master of Surgery (Ch.M.), for which a thesis is required.

With the celebration of its fiftieth anniversary, the Medical College is entering upon a new phase of teaching, *namely*, post-graduate instruction. This work will be continued each year. The object is to furnish a course which will be of value particularly to the general practitioner in the day to day routine of his work.

It is to be hoped that this venture into a new sphere of activity may maintain the consistently high standard which has been set in the past by the Manitoba Medical College and the Faculty of Medicine of the University of Manitoba.

#### MEDICAL SERVICES FOR "RELIEF" CASES

The plan for the provision of medical services for citizens in receipt of unemployment relief funds in Greater Winnipeg appears to be working in a reasonably satisfactory manner. From time to time minor difficulties have developed, but these have been cleared up by discussion between Dr. Moorhead's committee and the Relief Committee of the City Council. One of the most interesting aspects of the working of the plan is the effect which it will have on the number of hospital cases for which the municipal councils will be required to pay. It is too early to draw definite conclusions, but the Hospital Section of the Winnipeg Medical Society are checking the figures, and it is expected that the number of hospital cases will show a decrease.

The question of medical services for relief cases and indigents in rural areas was discussed at the regular meeting of the Executive of the Manitoba Medical Association, and is referred to in the minutes of that meeting.

## Manitoba Medical Association

### MINUTES OF EXECUTIVE MEETING

MINUTES of a meeting of the Executive of the Manitoba Medical Association, held in the club-rooms of the Medical Arts Building, Winnipeg, on Thursday, April 26th, 1934, at 6.30 p.m.

#### Present.

Dr. J. C. McMillan, chairman	Dr. F. W. Jackson
Dr. F. G. McGuinness	Dr. W. W. Musgrove
Dr. T. A. Pincock	Dr. C. W. Wiebe
Dr. A. F. Menzies	Dr. C. W. MacCharles
Dr. J. D. Adamson	Dr. J. S. McInnes
Dr. W. J. Elliott	Dr. E. D. Hudson
Dr. H. O. McDiarmid	Dr. G. W. Rogers
Dr. C. A. MacKenzie	Dr. Ross Mitchell
Dr. F. A. Benner	Dr. R. R. Swan
Dr. G. D. Shortreed	

#### Present by Request.

Dr. E. S. Moorhead	
Dr. A. J. Swan	[toba Municipalities
Mr. E. L. Stoney, President of the Union of Mani-	

Mr. John Spalding, Secretary-Treasurer of the Union of Manitoba Municipalities

Following dinner, the Chairman called the meeting to order at 7.30 p.m. Minutes of the last meeting of the Executive, held February 8th, 1934, were read by the Secretary and approved.

#### Medical Relief in Rural Manitoba.

Dr. Moorhead addressed the meeting and advised that Mr. Stoney and Mr. Spalding had been asked to attend to discuss the problem of medical relief in Rural Manitoba. He stated that there were some 175 municipalities within the province, and 113 for which we have information; 65 pay for medical relief on different scales, 19 of which are financially unable to pay; 48 municipalities are not paying for medical relief, of which number there are only 7 in poor financial condition. Dr. Moorhead then requested Mr. Spalding to give his opinion on the situation.

Mr. Spalding stated that there were a number of

municipalities in which there is no relief problem, which might account for a portion of the difference.

Discussion followed by the country members present, as follows:

Dr. McDiarmid: The Health Unit in Brandon is financed by the Rockefeller Foundation, who pay twenty-five per cent. The City is endeavoring to keep down hospital bills by seeing patients in their homes. The Health Unit doctor is doing as much relief work as possible.

Dr. Rogers: They have a relief problem in Dauphin and the surrounding municipalities, but no attempt is made to pay for attendance. Indigent cases are the greatest responsibility. Residents are put on relief for short periods only. Some scheme should be worked out to care for indigent cases.

Dr. Shortreed: Technically there is no unemployment relief in the municipalities in that district, covering Gilbert Plains, Grandview, Shell River and Boulton. The men work it out in the bush cutting wood. Municipalities will not admit debt for medical services unless on an order from the council. This is always furnished in cases of necessity. Indigents are much more of a question for decision than those on relief. Group insurance considered, but district too small.

Mr. Spalding, in answer to these questions, stated it was his opinion that the fault lay with the medical men, in that they had not approached the councils or discussed their problems with them.

Mr. Stoney stated that Dr. R. L. Ross of Morris had approached the municipal council and arrangements had been made to pay him sixty per cent. of his fees.

Dr. Moorhead then asked what the definition of "indigent" might include, but no definite reply to this question was given.

Dr. Hudson: Have no problem with reference to relief work in his district, but if arrangements could be made for the care of indigents it would be of great benefit. The council had approached him to make some arrangements.

Dr. Moorhead suggested that perhaps the Secretary should write to the country doctors, advising them to approach their respective councils. He asked Mr. Spalding to give his suggestions on a scale of fees, which he quoted.

Mr. Spalding: The average councillor gets 10c a mile for attending meetings, and an objection might be raised by some of them to paying doctors 25c a mile. The position of many of the municipalities is that they have run overdrafts with the Bank and have been unable to clear these up by the end of the year. In some cases the next year's taxes went to clear up these overdrafts and the municipalities only received the bare necessities during the interim. A meeting should be held with the Manitoba Union of Rural Municipalities and a delegation of the medical men. Something definite could be arrived at in this way.

Dr. Menzies: A serious side of this matter is that people in the country are going without medical services, and in many cases where it was important that they see a doctor this was not done, for the reason that they do not wish to incur the expense. He had no answer as to how this should be remedied, but felt that the municipalities could not pay anything like the amount to cover the attention the people required.

Dr. Moorhead: The separate classification of unemployment relief cases and indigent cases should be dropped, so far as the country is concerned. In Winnipeg, unemployment relief was singled out for the reason that this class was easily defined.

Dr. Rogers: A list of the dates of meetings of the municipalities should be obtained, and the places they are to be held.

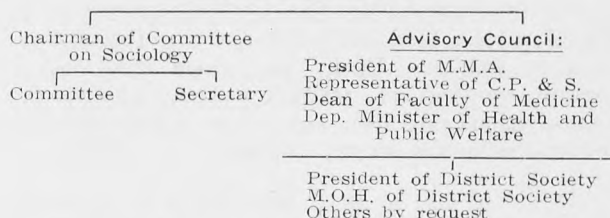
Following the above discussions, both Mr. Stoney and Mr. Spalding were thanked for their assistance, and retired from the meeting.

#### Resolution from Special Relief Committee.

Resolution from the Special Relief Committee, which had been forwarded to this Executive under date of April 26th, recommending that the work of that committee be turned over to the Manitoba Medical Association, and that a committee on Sociology be established, was read by Dr. A. J. Swan.

Dr. F. D. McKenty, in explanation of the above, presented the following chart, and explained the details of operation of this committee and advisory council:

#### M.M.A. EXECUTIVE



Dr. McMillan explained the proposed financial arrangements, whereby five per cent (5%) of the monies collected would be paid into a trust fund to meet expenses.

Following further discussion on the operation of this committee and the work still to be done, it was moved by Dr. H. O. McDiarmid, seconded by Dr. A. F. Menzies: That the following resolution be adopted by this Executive, effective May 1st, 1934:

THAT the Manitoba Medical Association should establish a committee on Sociology, with a permanent chairman on salary, to whom would be delegated the authority for carrying out the policies determined by the Executive of the Association. This chairman shall have authority to choose his own committee and secretary. The Association shall guarantee him a minimum salary of two hundred and fifty dollars (\$250.00) per month, with a maximum salary of three hundred dollars (\$300.00) per month, providing that the funds accruing from the assignments of the doctors' accounts rendered to municipalities in the province, for those in receipt of unemployment relief or other indigent persons, permit of this, after a deduction of fifty dollars (\$50.00) a month has been set aside for other expenses.

The Executive further resolves that Dr. E. S. Moorhead be appointed chairman of the committee on Sociology.

The Executive further resolves that, if funds accumulate beyond the amount specified above, namely, three hundred dollars (\$300.00) per month for the salary of the chairman, and fifty dollars (\$50.00) per month for other expenses, the percentage of the assignment of doctors' accounts be reduced so that in future they will only cover these two items.

The Executive further resolves that an Advisory Council be established, consisting of (1) the President of the Manitoba Medical Association, (2) a representative of the College of Physicians and Surgeons, (3) the Dean of the Faculty of Medicine of the University of Manitoba, and (4) The Deputy Minister of Health and Public Welfare.

—Carried.

#### Report of Finance Committee.

Dr. McGuinness submitted a short summary of the present finances of the Association and the report of the committee, consisting of Dr. C. A. MacKenzie, Dr. J. C. McMillan and himself. He stated that the



suggested grant to the Manitoba Medical College of five hundred dollars (\$500.00) was not deemed advisable, as the committee in charge of the Jubilee celebration could raise sufficient funds. With reference to the donation to the Friedman Test for Pregnancy, he stated that fifty dollars (\$50.00) could be guaranteed, but it was the opinion of the committee that it would not be necessary to put up the money.

Dr. Musgrove spoke in connection with the Jubilee Celebration, stating that a decision had been made by their committee to charge a registration fee of five dollars (\$5.00), and at the present time it looks as though finances will be assured with this fee, including the amount donated by the College of Physicians and Surgeons. He advised that they have some splendid clinicians coming for the week, and that it was quite evident that the meeting would be a complete success. Dr. Musgrove then retired from the meeting.

Dr. McGuinness then advised that there was a movement on foot to make a presentation to Dr. Moorhead and Dr. Swan for the valued services they have rendered to the profession, and that it had been proposed that three hundred dollars (\$300.00) be donated by the Manitoba Medical Association, three hundred dollars (\$300.00) by the College of Physicians and Surgeons, and two hundred dollars (\$200.00) by the Winnipeg Medical Society.

It was moved by Dr. F. G. McGuinness, seconded by Dr. C. A. MacKenzie: That the Manitoba Medical Association donate the sum of three hundred dollars (\$300.00) towards this presentation, to be repaid when the surplus of funds of the Special Relief Committee warrants this. —Carried.

#### Workmen's Compensation Board.

Dr. McMillan reported that the only changes in the previous suggestions with reference to the above were that the Workmen's Compensation Board had requested a panel of doctors for appointment to the Referee Board, one member to be appointed for a one-year term and one for a two-year term, the one-year appointee to act as chairman and the two-year appointee as vice-chairman for the current year. At the end of the year, the chairman would automatically resign and the vice-chairman would become chairman for the following year, a new member being appointed at the beginning of the year to act as vice-chairman. No reply had as yet been received from the commissioner regarding these appointments.

#### Ophthalmology and Cystex Broadcasts.

Dr. Mitchell reported that the matter of ophthalmology broadcasts had been reported to Mr. Lowry, Commissioner of the Manitoba Telephone System, and that Mr. Lowry had been under the impression that the party giving these broadcasts was a duly qualified practitioner. This misunderstanding had been corrected.

With reference to the Cystex broadcasts, Mr. Lowry had stated that this programme was one that was featured by the Canadian Radio Commission, and the matter had been referred by them to the Federal Minister of Health. Consequently, this should be dealt with by the Canadian Medical Association.

It was moved by Dr. Ross Mitchell, seconded by Dr. J. S. McInnes: That the Secretary be instructed to write Mr. Lowry, stating that this Association is opposed to the Cystex programme on the grounds that it is misleading and distasteful, and that a copy of this be sent to Dr. T. C. Routley, asking him to take the matter up with the Canadian Radio Commission. —Carried.

#### Fees for Medical Services to Inmates of Government Institutions.

Dr. MacKenzie reported on the above, advising that he had interviewed the Attorney-General, and following negotiations through Mr. John Allan and the doctors in charge of the institutions it had been finally agreed that fees would be paid for consulting work.

#### Debt Adjustment Act.

The Secretary read letter addressed to Dr. Ross Mitchell, from Mr. G. S. Rutherford, Commissioner of the Debt Adjustment Board, under date of April 21st. Copy of this letter and particulars had been forwarded to Dr. R. L. Ross of Morris, and his reply, under date of April 25th, was read to the meeting.

#### Extra Mural Tour.

Letter was read from The Pas, under date of March 20th, asking that a team be sent to The Pas this Spring, also a request from the North-Western District Society, under date of April 10th, for speakers for a meeting at Hamiota, May 8th. It was stated that Dr. J. E. Lehmann had agreed to go to Hamiota, along with the Secretary.

Dr. McMillan advised that we had received a grant from the College of Physicians and Surgeons of three hundred dollars (\$300.00) to cover some of this work, and asked the opinion of the meeting as to how this should be spent.

It was felt that the expense of a trip to The Pas would be heavy, but that full information should be obtained with regard to the type of programme preferred, and the matter of expenses.

It was moved by Dr. A. F. Menzies, seconded by Dr. E. D. Hudson: That, if a tour is planned, this be arranged to take place about the end of June.

Discussion followed, in which Dr. McInnes stated that the money received from the College should be carefully dealt with and that one-half only should be spent on a tour, also that it would be better to leave the choice of subjects with the districts, who are better able to judge what type of programme is most suitable.

As an amendment to Dr. Menzies' motion, it was moved by Dr.

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F. G. McGuinness, seconded by Dr. C. A. MacKenzie: That it be left with the district societies concerned to request the type of programme they desire. —Carried.

#### **Appointments to C.M.A. Council.**

It was moved and seconded that the following be appointed to the C.M.A. Council for the coming meeting: Dr. D. Nicholson, Dr. P. H. T. Thorlakson, Dr. E. S. Moorhead, Dr. J. D. Adamson, Dr. G. S. Fahrni. —Carried.

#### **Annual Meeting.**

It was suggested by Dr. W. J. Elliott that the matter of the time and place of the annual meeting be left with the President and Secretary.

It was moved by Dr. H. O. McDiarmid, seconded by Dr. A. F. Menzies: That the Winnipeg members of this Executive appoint the conveners of committees for the Annual Meeting. —Carried.

#### **Correspondence.**

Letter was read from Dr. R. F. Yule of Kenton, under date of March 20th, with reference to a municipal doctor in the Municipality of Daly. The Secretary was instructed to get a legal opinion as to the reading of the Act, and then to advise the doctors that they need not attend these cases.

Letter was read from Dr. T. C. Routley, under date of March 16, enclosing newspaper clipping of an advertisement re. "Nixoderm" in which a testimonial and photograph of Dr. Mary Whittaker is published. The Secretary was instructed to write Dr. Routley, advising him that Dr. Whittaker is now a resident of Toronto, and if possible to forward her address.

Letter was read from the Manitoba Association of Registered Nurses, under date of March 2nd, asking that a member of this Association be appointed on their Directory Committee.

It was moved by Dr. T. A. Pincock, seconded by Dr. F. G. McGuinness: That Dr. F. A. Benner be appointed our representative. —Carried.

Letter was read from Dr. A. J. McIntyre of Elgin, under date of March 28th, re. an irregular practising in the City of Brandon. The Secretary was instructed to refer this matter to the College of Physicians and Surgeons.

Letter was read from Dr. T. C. Routley, under date of April 16th, re. examinations of the Medical Council of Canada by sections. The Secretary was instructed to refer this matter to the College of Physicians and Surgeons.

The meeting then adjourned.

## **AN APPEAL TO OUR ALUMNI**

Half a century has passed since the Manitoba Medical College was founded by a small group of doctors, who typified the pioneer spirit of this land in its truest and best sense. That these men builded well is now everywhere accepted, but that they builded better than they knew has also to be admitted. Our graduates in this and other lands have left and are making records comparable to the best of any medical school, and to these we rightfully give full praise. But it is to the family doctor of these Western lands we give chief honor, the man who has justified to the greatest degree the undertaking of our college founders and who has written largely into the character of these lands.

We are commemorating the founding of the college during the week beginning May 14th, and the programme for this event has already reached you. It is expected that this course will not alone be profitable from a scientific point of view, but also that it will afford the

opportunity of again greeting old friends whom we have not seen for a long while, to recall the time gone by, living again our student days, and especially giving us an opportunity of paying our best respects to those who labored in the early days of our college's history as teachers and directors of its affairs.

On Wednesday evening, May 16th, an opportunity is to be given us to do this at an alumni dinner and dance. Among the speakers at this dinner will be our beloved Dr. H. H. CHOWN, who joined with the college teachers in its first years and who served it as Dean for the longest period of any of his successors in this office.

On behalf of the Manitoba Medical Alumni Association, I extend to all a cordial greeting and invitation to be present at these meetings, and especially the Wednesday evening dinner and dance.

W. W. MUSGROVE,

*President.*

## **THE CLASSIFIED TELEPHONE DIRECTORY**

*Report from Executive of Winnipeg Medical Society*

THERE has been considerable discussion during the past winter in the meetings of the Winnipeg Medical Society and in the Executive about listings of physicians and surgeons in the classified Telephone Directory. A new Directory will shortly be issued, so that the subject is again of interest. It will be recalled that the Executive passed a resolution in December expressing disapproval of separate headings for the various specialties; and that some of the men so listed expressed annoyance when the Directory came out, because they stated that they had been assured by the canvassers that their names would not appear unless the plan were approved by the Winnipeg Medical Society.

In the Directory shortly to be issued these separate headings will not appear. The Telephone Company are, however, offering what they call "extra line matter" (in association with the general classification of physicians and surgeons). This extra line matter

will be paid for by the subscriber. One who avails himself of it may have printed after his name any of the following: (1) his specialty. (2) his office hours. (3) an alternate call, e.g. his residence, or "if no answer call the Doctors Registry."

This question of extra line matter was discussed at a recent meeting of the Executive, and no serious objection was raised against it. The opinion was expressed that anything that is regarded as ethical in the main Directory could not be objected to in the classified Directory. And from the standpoint of service to the public the extra line matter has much to recommend it. It is not much use to a man who wants a doctor in the middle of the night to find out his office number. Neither does an Eye and Ear Specialist wish to be disturbed by a call to see a sick baby or an Internist by a call to an accident case.

A. P. MacKINNON,

*President.*



## Department of Health and Public Welfare

### NEWS ITEMS

**ROCKY MOUNTAIN SPOTTED FEVER:**—There is widely scattered throughout the world a rather large group of diseases commonly referred to as the typhus-like diseases, which have many characteristics in common, and are characterised in man by sudden onset, chills, fever, severe headache, various degrees of prostration, mental symptoms and an exanthem. An insect vector has been incriminated epidemiologically in all and proved in some.

During the past two years Rocky Mountain spotted fever has changed from a disease of supposedly purely sectional concern to one of potential interest to all parts of the United States and some parts of Canada. In this country the disease appears to be of little importance at the present time, as the Dominion Vital Statistics for the past five years do not record any deaths as being due to Rocky Mountain spotted fever. Cases undoubtedly have occurred, and if their true nature has been recognized, one must infer that the disease has been of a comparatively mild type. Two known cases have been treated in Winnipeg hospitals: one acquired the infection in Northern Manitoba and the second, occurring during the summer of 1933, became infected while in the Lac du Bonnet area. The virus occurs in nature in Manitoba, but to what extent is unknown, and although it gives rise to a mild type of the disease, the possibility of infection should be borne in mind.

The vector in the instance of Rocky Mountain spotted fever is the tick, as it is also for four other specific diseases in North America, viz.: Tick paralysis, tularemia, American Mountain tick fever and certain indolent cutaneous ulcers of undetermined character.

Outside of North America is a similar disease entity, known in one instance as Sao Paulo disease and in another as Mediterranean Exanthematic fever. Immunological investigation indicates that they are both identical with spotted fever. The vector in each instance is the tick.

The Eastern type of spotted fever occurs mostly in the late spring and throughout the summer; cases in men predominate, and the disease tends to recur in the same localities. Infection is derived from the bite of an infected tick or through crushing an engorged tick. The incubation period is usually from three to seven days, the onset abrupt, generalized aching and considerable prostration. The rash appears most frequently on the third or fourth day. The site of first appearance is nearly always the wrists and ankles, then the back and, rapidly becoming generalized, it spreads in a centripetal fashion, becoming complete in two or three days. The lesions are at first roseolar macules from 2mm to 8mm in diameter, which often fade in the mornings and reappear with the rise of temperature during the afternoon. They grow more distinct from day to day and by the middle of the second week are definitely petechial in all but the milder cases. The rash in its full development is purpuric and, as a rule, most abundant and intense on the wrists, ankles, legs, upper part of the back, shoulders, lateral surfaces of the arms and the buttocks in the order named. Sometimes there is a branny desquamation, especially over the legs, commencing late in the disease or early in convalescence. The face is flushed or dusky and the eyes injected. Occasionally there is marked edematous swelling of the face, hands, feet and genitalia. Necrosis of skin of the extremities may occur.

A very few years ago it was thought that Rocky Mountain spotted fever occurred only west of the Mississippi River, but since 1930 fully substantiated cases have been reported from Maryland, Delaware, North Carolina, South Carolina, Pennsylvania, Virginia, District of Columbia, Louisiana, Texas, Missouri, Tennessee, Georgia, New York, New Jersey and Minnesota. In the light of this recent investigation it is likely that doubtful cases reported in earlier years were actually of this disease. The following table illustrates the prevalence of the disease at the present time according to the weekly reports of the United States Public Health Service:

ROCKY MOUNTAIN SPOTTED FEVER UNITED STATES 1933

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total
California	-	-	1	1		8		1	1				12
Colorado	-	-			7	2	2						11
Dist. of Columbia						3	3	1					7
Georgia	-	-	-						2				2
Idaho	-	-	-	2	8	20	17	4					51
Indiana	-	-	-			1							1
Iowa	-	-	-			2	2		1				5
Maryland	-	-			1	21	13	5					40
Minnesota	-	-			1								1
Montana	-	-		14	23	25	8	1	1			1	73
New York	-	-				1		2					3
Nevada	-	-	-	3	5	3	3						14
North Carolina	-						9	11	6	1	1		28
Oregon	-	-		12	10	16	4			1			43
Pennsylvania	-		1									1	2
Tennessee	-	-						2					2
Texas	-	-	-			8							8
Virginia	-	-			2	4	11		2				19
Washington	-	-		2		1							3
Wyoming	-	-	4	13	31	30	20	4	1				103
TOTAL	-	-	7	54	100	142	79	27	14	2	1	2	428

The virus of the disease is carried in nature by ticks and may be transmitted by them to man. Recent investigations on eight varieties of ticks in the United States indicate that five are likely natural carriers of the spotted fever virus and three are established carriers, and the means of transmission to man.

The Rocky Mountain Wood Tick (*Dermacentor Andersoni*) is the largest recognized carrier of the virus; it is confined largely to

the Rocky Mountains and contiguous states, giving rise to what is known as the Western type of the disease, having a mortality up to ninety per cent., while Eastern cases show a mortality of from five to thirty per cent.

The range of the American Dog Tick (*Dermacentor Variabilis*) extends over the entire Eastern United States and as far west as to overlap that of *Dermacentor Andersoni*, and north far into Canada. The best known host is

the dog, but it has been reported on most domestic animals and deer. The larval and nymphal forms are found on wood mice and common field mice.

The Rabbit Tick (*Hæmaphysalis leporis-palustris*) does not normally bite man, but is present throughout the entire United States. It infects all species of rabbits and many species of ground frequenting birds, and continually carries a type of spotted fever virus that is seldom capable of producing in guinea-pigs more than a symptomless immunizing infection; but the virus-carrying ability, the wide distribution, the great numbers and the known host relationships of this tick point to it and its hosts as of possible considerable fundamental importance among the factors that are concerned in the prevalence and distribution of spotted fever in nature.

The virus of Rocky Mountain spotted fever is found in these ticks in nature. It is passed from generation to generation through the medium of the egg and, in the case of one variety, it is known that there may be sexual transmission of the virus from infected to non-infected ticks.

There is no reason to be unduly afraid of this disease, as it is not transmitted from man to man, and a few precautions will usually prevent the individual from being infected. The disease is essentially one of rural dwellers, or those living temporarily in the country, as the ticks are acquired by both man and animals mainly from the low bushes along roads and trails; they are most likely to be prevalent where wild rodents are numerous.

There is no specific treatment for the disease, so prevention is the only means of control:

(a) A vaccine is available, which is recommended for those going into known tick infested areas. This vaccine is prepared by the United States Public Health Service at Hamilton, Montana; it has been administered to over 25,000 persons in Montana, Wyoming, Idaho and Oregon, and found to provide quite adequate protection against the milder type of the disease, while in the highly virulent type the degree of protection is usually sufficient to cause a marked amelioration of the customary very severe symptoms and to insure the recovery of most cases. Vaccination each year is necessary.

(b) *Tick control*: This would appear to be a most difficult problem, but in some portions of the United States the disease assumes such proportions that tick control has been undertaken as a State public health measure.

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(c) Personal prophylaxis is most effective by avoiding tick-infested areas. If exposure is anticipated, appropriate wearing apparel, which will prevent the ticks from crawling up inside the clothing, should be worn; search of the clothes two or three times a day should be made, as the ticks do not usually attach themselves right away and are seldom able to infect a person until a few hours after they have become attached to the skin. A favourite site of attachment is on the back of the neck at the hair line, so that frequent exploration of this and other parts of the body, and careful removal of the ticks without crushing, is of considerable value. Ticks are most numerous in May, June and July, and most likely found on the shrubbery along trails or little used roads.—C.R.D.

**FOODS: THEIR CONTAMINATION:**—The surfaces of raw fruits and vegetables, as ordinarily handled, are in constant contact with dust particles from man and animals. A large number of micro-organisms of many species are found in the mucilaginous products of the juices. A colony count was found to average 250,000 per gram in spinach, and 135,000 per kernel within the husk and in contact with the individual kernels in corn. Washing, unless under strictly controlled conditions, may increase rather than decrease the bacterial content of food. When we turn to flesh foods we find that invasion by bacteria from the alimentary canal follows quickly after the animal is killed, whilst the subsequent handling process increases this, also the transport, etc. The gross carelessness observed in handling meats, their exposure on hooks and blocks, furnish a favourable substratum for members of the *B. paratyphosis* (*B. enteritidis* and *B. aertrycke*) meat poisoning organisms. Only adequate cooking can protect from these. Spinach, lettuce and asparagus may become so heavily contaminated with bacteria that they feel slimy to the fingers. "Pickles" are foods soured by the activity of the *Lacto bacilli* under controlled conditions; then sauerkraut is simply pickled cabbage, by anaerobic fermentation, which suppresses other forms of bacilli. Lactic acid in certain concentrations reduces other bacteria to negligible amount and hence is an effective preserving agent. Control of bacteria in food is attained by drying, by preserving agents, or by cold. In studies of meat in transit from Australia to London, certain molds were found to develop colonies at temperatures down to +22° F. It was also shown that micro-organisms would grow slowly at temperatures below the freezing point, as long as crystallisation of the substratum did not occur. Products from the refrigerator ultimately became unfit even under the most careful handling. Eggs, for instance, so lose by cold storage that above a year they are not marketable, but within that time, the user of eggs will detect deterioration.

Another method in destruction of the micro-organisms is by cooking. What danger there may be from infection has been covered by canning. But extensive tests of canned foods have shown that the spores of an aerobic bacteria may be present, although not able to grow. Such foods keep. If the foods contain highly resistant spores which survive the usual cooking process (for example, canned corn) are allowed to cool slowly for some time, the spores grow and spoil the food.

The specific bacteria applied to food poisoning may be grouped as (1) paratyphoid bacilli; (2) *Clostridium botulinum*, varieties A., B. and C.; and (3) miscellaneous bacteria. (1) Paratyphoid bacilli may be readily distinguished from the *B. coli* group, owing to their inability to ferment lactose, and from *B. typhosis* by their gas production in dextrose. The paratyphoid group has two chief food poisoning bacteria: *B. enteritidis* and *B. aertrycke*. *B. enteritidis* was first isolated by Gartner in 1888 in the outbreak at Frankenhausen. The meat was from a cow which

had been ill from enteritis. Gastro-intestinal symptoms developed in two hours, and death sometimes occurs within forty-eight hours. *B. enteritidis* has been found in milk, brawn and sausage meat, beef stew, veal, etc. Several recorded outbreaks have been due to contamination of the food with commercial rat viruses. *B. aertrycke* is often found in epidemics in laboratory animals, and frequently in infection of cattle and sheep. It has been reported in a large number of human food poisoning outbreaks. In 100 recent outbreaks in Great Britain, the *B. aertrycke* was found in fourteen instances, and it was considered the principal cause in thirteen others. In the same series *B. enteritidis* was isolated but once, and suspected in three other instances. The symptoms shown by these two organisms show no noteworthy divergence. Either may cause death. It is not certain that the bacillus isolated by De Nobe in a food poisoning outbreak in Aertryck was the exact prototype of the organism called *B. aertrycke*, but the latter is regarded by some as an independent form culturally and immunologically. Little has been ascertained about its source, although it has been found in many foods. (2) *C. botulinum*, A., B. and C. These are spindle-shaped, anaerobic spore-bearing rods which generate a poisoning toxin. Type A. produces by far the most potent toxin; the ratio of the lethal rise for the three types being given as 1: 50: 125. The heat resistance is greater in types A. and B., and varies from four minutes at 120° C. to 330 minutes at 100° C. The death-point of C. is considerably lower. The spores are common in soil, and must adhere frequently to vegetables, yet botulism is rare. The absorption and mode of action of botulism toxin are quite obscure. The toxin is unique in being the only known exotoxin that is absorbed from the digestive tract. Death is due to failure of the respiratory muscles or of the heart. The early development of the symptoms and the antitoxin not being at hand, usually defy prompt administration.

Miscellaneous bacteria have caused food poisoning by invasion or by toxic products. Thus *B. proteus* are found in decomposing animal matter and not infrequently swallowed with food, and a number of outbreaks of food poisoning have been reported by several observers, but it is concluded by W. G. Savage that for "none of them was it established that *B. proteus* was etiologically concerned." *Staphylococcus* may produce acute attacks of gastro enteritis, as in the case of a white staphylococcus which occurred in pure culture in the udder of a cow. Symptoms were produced in a volunteer who drank the milk inoculated with the suspected staphylococcus. *Streptococcus* has been reported in cheeses, but it is not certain. It is probable that bacteria of various kinds, as yet unidentified, cause epidemics of food poisoning, but we are ignorant of the factors concerned in the products of many epidemics and scattered cases.

#### COMMUNICABLE DISEASES REPORTED — Urban and Rural — March, 1934. Occurring in the Municipalities of:—

**Measles:** Total 1640 — Winnipeg 1366, St. Boniface 164, St. Vital 71, Fort Garry 13. (Late reported, February: Fort Garry 1), Ritchot 6, Strathcona 5, Kildonan West 4, Woodlands 4, Kildonan East 2, Boissevain 1, Flin Flon 1, St. James 1, Transcona 1.

**Chickenpox:** Total 125 — Winnipeg 79, Kildonan East 12, St. Boniface 10, St. Vital 10, St. Paul East 8, Fort Garry 1, Kildonan West 1, Minnedosa 1, Transcona 1, Woodlands 1. (Late reported, February: Cypress North 1).

**Scarlet Fever:** Total 81 — Winnipeg 35, Morris Rural 6, Norfolk South 6, Tache 5, Grandview Town 3, St. Boniface 3, Montcalm 2, Roblin Rural 2, Swan River Rural 2, Victoria 2, Assiniboia 1, Carman 1, Kildonan East 1, Lorne 1, Morton 1, Rosser 1,

Saskatchewan 1, Stonewall 1, St. Andrews 1, St. Vital 1, Turtle Mountain 1. (Late reported, January: Rosser 1, Unorg. Chatfield 3).

**Mumps:** Total 31—Winnipeg 23, St. Boniface 3, Louise 2, Morris Rural 2, Montcalm 1.

**Whooping Cough:** Total 26—Winnipeg 22, Fort Garry 3, Dauphin Rural 1.

**Tuberculosis:** Total 23—Winnipeg 13, St. Vital 2, The Pas 2, Unorganized 2, Bifrost 1, Portage la Prairie City 1, St. Andrews 1, St. Paul West 1.

**Diphtheria:** Total 19—Winnipeg 9, St. Vital 2, Argyle 1, Montcalm 1, Rhineland 1, Transcona 1, Unorganized Fisher Branch 1, Unorganized Sprague 1. (late reported, January: Ellice 1, Kreuzburg 1).

**Erysipelas:** Total 8—Winnipeg 4, Armstrong 1, Rockwood 1, St. Boniface 1, St. Paul West 1.

**Influenza:** Total 6—Saskatchewan 1, Winnipeg 1. (Late reported, January: Kildonan East 1, Rosedale 2, Unorganized 1).

**Typhoid Fever:** Total 5—Hanover 5.

**Anterior Poliomyelitis:** Total 1—(Late reported, January: Unorganized 1).

**Cerebrospinal Meningitis:** Total 1—Rosedale 1.

**Lethargic Encephalitis:** Total 1—Charleswood 1.

**Puerperal Fever:** Total 1—Montcalm 1.

**Trachoma:** Total 1—Unorganized 1.

**Venereal Disease (Manitoba)**—Gonorrhoea, 85; Syphilis, 42. Total 127.

## DEATHS FROM ALL CAUSES IN MANITOBA

for the Month of January, 1934

**URBAN**—Cancer 35, Pneumonia (all forms) 29, Tuberculosis 8, Congenital 7, Diphtheria 2, Influenza 2, Measles 2, Chickenpox 1, Puerperal 1, Erysipelas 1, other causes under one year, not included elsewhere 8, all other causes 133, Stillbirths 10. Total 239.

**RURAL**—Pneumonia (all forms) 18, Tuberculosis 15, Cancer 14, Influenza 6, Puerperal 6, Diphtheria 3, Erysipelas 2, Cerebrospinal Meningitis 1, Whooping Cough 1, other causes not included elsewhere under one year of age 12, all other causes 110, Stillbirths 15, Congenital 2. Total 205.

**INDIANS**—Tuberculosis 7, Whooping Cough 5, Pneumonia (all forms) 2, Congenital 2, Cancer 1, all other causes 2. Total 19.

# DOCTORS . . .

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# COCOMALT

*Accepted by the American Medical Association*

## Committee on Foods

THE FOLLOWING PRODUCTS HAVE BEEN ACCEPTED BY THE COMMITTEE ON FOODS OF THE AMERICAN MEDICAL ASSOCIATION FOLLOWING ANY NECESSARY CORRECTIONS OF THE LABELS AND ADVERTISING TO CONFORM TO THE RULES AND REGULATIONS. THESE PRODUCTS ARE APPROVED FOR ADVERTISING IN THE PUBLICATIONS OF THE AMERICAN MEDICAL ASSOCIATION, AND FOR GENERAL PROMULGATION TO THE PUBLIC. THEY WILL BE INCLUDED IN THE BOOK OF ACCEPTED FOODS TO BE PUBLISHED BY THE AMERICAN MEDICAL ASSOCIATION.

RAYMOND HERTWIG, Secretary.

### COCOMALT

(Sucrose, Skim Milk, Cocoa, Malt Extract, Egg and Added Vitamin D)

Manufacturer—R. B. Davis Company, Hoboken, N.J.

**Description**—A powdered food for the preparation of table beverages; contains sucrose, skim milk, cocoa, malt extract, whole egg, vanillin flavoring and added vitamin D (irradiated ergosterol).

**Manufacture**—Cocoa (including added irradiated ergosterol), sucrose, and skim milk and egg powders are thoroughly mixed with malt syrup and vanillin flavoring. The mixture is dried at a relatively low temperature to avoid destruction of the vitamin and diastatic values. The finished product is ground, bolted and automatically packed in an atmosphere of carbon dioxide in hermetically sealed containers. The carbon dioxide composes about 75 per cent of the gas mixture in the container.

**Analysis** (submitted by manufacturer)—

Moisture	0.8
Ash	3.2
Fat (ether extract)	2.9
Protein (noncaffeine and nontheobromine N X 6.25)	14.1
Caffeine	0.09
Theobromine	0.21
Crude fibre	1.4
Carbohydrates other than crude fibre (by difference)	77.0
Calcium (Ca)	0.34
Phosphorus (P)	0.43
Lintner value	6.3

**Calories**—3.9 per gram; 111 per ounce.

**Vitamins**—Vitamin D is incorporated in Cocomalt (under license by the Wisconsin Alumni Research Foundation) to the extent of approximately 39 Steenbock units per ounce. Biologic assay shows the presence of from 40 to 45 Steenbock D units per ounce.

**Claims of Manufacturer**—Especially intended for the preparation of table beverages with milk. Cocomalt enhances the food value and flavor of milk. Many who dislike plain milk, especially children, invalids, convalescents and the aged, enjoy Cocomalt-milk beverage. One ounce of Cocomalt, which is recommended for each glass of beverage, contains from 40 to 45 vitamin D units (Steenbock) and richly contributes to the vitamin D dietary needs of the body. A hot beverage promotes relaxation. "A hot Cocomalt" before retiring is an aid to restful sleep.

Reprinted from the June 4th issue Journal of the American Medical Association, Page 1991.

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## Western Canada Medical History

### CHOLERA EPIDEMIC IN RED RIVER SETTLEMENT 1846

By ROSS MITCHELL

Sheriff Alexander Ross, the historian of the Red River, writes:

"Our fourth decade, now to be treated of, is the epidemic of this year, 1846. During this pest, for we can give it no milder name, the colony was overwhelmed with terror. The winter had been uncommonly mild. In January the influenza raged, and in May the measles broke out; but neither of these visitations proved very fatal. At length, in June, the bloody flux began its ravages among the Indians of the White Horse plains, and soon spread with fearful rapidity and fatal effect among the whites. 'In Rama was there a voice heard, lamentation and weeping and great mourning.' In Red River that voice was heard this year; like the great city in Egypt, 'for there was not a house where there was not one dead!'"

"In no country, either of Europe or America, in modern times—not under the severest visitation of cholera—has there been so great a mortality as in Red River on the present occasion. Not a smiling face in a summer's day. Hardly anything to be seen but the dead on their way to their last home; nothing to be heard but the tolling of bells and nothing talked of but the sick, the dying and the dead. In other more populous places such things might be more common and less horrifying, but in a country hitherto so healthy and a population so scant it was a new and awful sight. From the 18th of June to the 2nd of August the deaths averaged seven a day, or 321 in all; being one out of every sixteen of our population. Of these one-sixth were Indians, two-thirds half-breeds and the remainder whites. On one occasion thirteen burials were proceeding at once. Many houses were closed altogether, not one of the family, old or young, being left in them."

\* \* \* \* \*

In the middle of last century the Red River Settlement was a small oasis of some 5,000 people in a wilderness of prairie. For the most part the health of the inhabitants was remarkably good and the inhabitants lived a sort of arcadian existence with the monotony of the year interrupted only by the departure and arrival of the buffalo hunters on the annual hunt. The extract, however, from Sheriff Alexander Ross' *The Red River Settlement*, now a very rare book, describes the epidemic of 1846. In his literary style Ross resembles Defoe in the

*Journal of the Plague Year*. Fortunately after this visitation in midsummer the gloom was lifted by the arrival in September of the Sixth Regiment under Lt. Col. Crofton which had been sent out by the British Government owing to the threat of war over the Oregon boundary. All the officers of this force were men of fine character and the presence of a body of troops under military discipline restored order to the settlement, heightened social activities and increased the money in circulation.

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standing mineral and vitamin advantages of Mead's Cereal with great ease of preparation.

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# Clinical Week Programme

**MONDAY, MAY 14th**

**9.00 a.m. – 12.00 noon**

Registration—Manitoba Medical College.

**10.30 a.m. – 12.00 noon**

**MOVING PICTURES:**

“Infections of the Hand”

“Physical Examination of the Infant”

“Some Diagnostic and Therapeutic Procedures”  
(Pædiatrics)

“Breech Presentation with Manual Aid”

“Ocular Nystagmus in Children” — Dr. J. McGillivray.

**12.30 – 2.00 p.m.**

Lunch—ADDRESS:

“The Place of Public Health on the Medical Curriculum”—J. G. Fitzgerald, M.D., LL.D.,  
Dean of the Faculty of Medicine, Univ. of  
Toronto; Director Toronto School of Hygiene.

**2.30 – 5.00 p.m.**

**“FRACTURES”**

Dr. H. P. H. Galloway, chairman.

“Fractures of the Elbow in Children”—Dr. H.  
P. H. Galloway.

“The Value of Non-Padded Plaster Casts”—Dr.  
J. E. Lehmann.

“First Aid and Transportation”—Dr. K. C. McGibbon.

“Fractures of the Neck of the Femur”—Dr. W.  
A. Gardner.

“Methods of Applying  
Traction”

“Reduction of Fractures  
Under Local Anæsthe-  
sia”

“Some End Results—Good  
and Bad”

Dr. A. P. Mackinnon

**8.00 p.m.**

Ceremonial Meeting and Reception  
Winnipeg Auditorium.

*Meetings will be held in the Medical College  
unless otherwise specified.*

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# Clinical Week Programme

**TUESDAY, MAY 15th**

**9.00 – 10.30 a.m.**

Clinical-Pathological Conference—Dr. C. R. Gil-mour and Dr. Wm. Boyd.

**10.30 – 11.00 a.m.**

“Subacute Bacterial Endocarditis” — Dr. Fred-erick Cadham.

**11.00 a.m. – 12.15 p.m.**

Small Group Clinical Demonstrations.

**12.30 – 2.00 p.m.**

Luncheon—ADDRESS:

“Flights from Medicine”—Dr. R. L. McGibbon, Saskatoon.

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**2.30 – 5.00 p.m.**

“SURGICAL EMERGENCIES”

Dr. B. J. Brandson, chairman.

“Treatment of Head Injuries”—Dr. O. S. Waugh.

“Emergencies of the Upper Abdomen”—Dr. N. J. MacLean.

“Treatment of Intestinal Distension by Suction Through a Duodenal Tube”—Prof. Wangensteen, Univ. of Minnesota.

“Late Appendicitis”—Dr. B. J. Brandson.

**8.30 p.m.**

SCIENTIFIC MEETING—Guest Speakers:

“Chronic Arthritis”—Dr. A. A. Fletcher, Toronto

“Diffuse Arterial Disease with Hypertension; Clinical Types”—Dr. N. M. Keith, Rochester, Minn.

Discussion Opened by Dr. J. D. Adamson.

*Meetings will be held in the Medical College  
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# Clinical Week Programme

WEDNESDAY, MAY 16th

Morning

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3.00 p.m.

CLINICAL LECTURES:

“Medicine and Surgery”

“Medical Management of Ascites” — Dr. N. M. Keith, Rochester, Minn.

“Nutritional Problems in Chronic Ill-Health” — Dr. A. A. Fletcher, Toronto.

“A Consideration of the Diagnostic and Therapeutic Aspects of Acute Abdominal Lesions” — Prof. Wangsteen, Univ. of Minnesota.

7.00 p.m.

ALUMNI—DINNER AND DANCE  
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## Clinical Week Programme

THURSDAY, MAY 17th

9.00 – 11.00 a.m.

TUMOR CLINIC

Dr. Wm. Boyd, chairman.

“The Indications for Biopsy”—Dr. R. W. Richardson.

“Grading of Malignancy; Its Bearing on Treatment”—Dr. A. W. S. Hay.

“Lip and Oral Cancer”—Dr. M. R. MacCharles.

“Cancer of the Breast”—Dr. J. A. Gunn.

“Enlarged Lymph Glands of the Neck”—Dr. Wm. Boyd.

11.00 a.m. – 12.15 p.m.

SMALL GROUP CLINICAL  
DEMONSTRATIONS.

*Meetings will be held in the Medical College  
unless otherwise specified.*

12.30 – 2.00 p.m.

LUNCHEON—Winnipeg General Hospital.

ADDRESS:

Prof. Egerton Pope, Univ. of Alberta,  
Edmonton.

2.30 – 5.00 p.m.

“SYMPOSIUM ON FUNCTIONAL  
DISORDERS”

Dr. Chas. Hunter, chairman.

“Aetiology of Neurosis”—Dr. Gilbert Adamson.

“Neurosis and Psychosis: Differential Diagnosis”  
—Dr. W. M. Musgrove.

“Neurosis and Physical Disease: Differential  
Diagnosis”—Dr. Chas. Hunter.

“Treatment of Neurosis”—Dr. A. T. Mathers.

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# Clinical Week Programme

**FRIDAY, MAY 18th**

**9.00 – 11.00 a.m.**

**“OBSTETRICS and GYNÆCOLOGY”**

Dr. D. S. Mackay, chairman.

“Obstructed Labour”—Dr. O. Bjornson.

“Toxæmias of Pregnancy”—Dr. Ross Mitchell.

“Cancer of the Cervix”—Dr. J. D. McQueen.

**11.00 a.m. – 12.15 p.m.**

**SMALL GROUP CLINICAL  
DEMONSTRATIONS.**

**2.30 – 5.00 p.m.**

**“MEDICAL SYMPOSIUM”**

“A Short Review of Digitalis Therapy and the Use of Modern Diuretics” — Dr. C. R. Gil-mour.

“The Modern Treatment of Anæmias” — Dr. L. G. Bell.

“Essential Hypertension”—Dr. J. D. Adamson.

“Common Types of Diarrhœa in Adults; Their Significance, Diagnosis and Treatment” — Dr. H. D. Kitchen.

**8.30 p.m.**

**THE GORDON BELL MEMORIAL LECTURE.**

“Growth — Normal and Abnormal” — Dr. Wm. Boyd. (Under the Auspices of the Winnipeg Medical Society).

*Meetings will be held in the Medical College  
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# Clinical Week Programme

**SATURDAY, MAY 19th**

**9.00 – 11.00 a.m.**

**“DISEASES OF CHILDREN”**

Dr. Gordon Chown and Dr. J. D. McEachern,  
Chairmen.

“The Acute Abdomen in Children”—Dr. Harold Popham and Dr. J. Stewart McInnis.

“Pyuria in Children”—Dr. J. D. McEachern and Dr. O. J. Day.

“Some Aspects of Tuberculosis in Childhood”—Dr. Bruce Chown and Dr. Daniel MacIntyre.

“The Acute Ear in Infancy and Childhood”—Dr. F. A. MacNeil.

‡ ‡ ‡ ‡

**SMALL GROUP CLINICS AND  
DEMONSTRATIONS.**

Heart—Dr. John M. McEachern.

Varicose Veins and Ulcers — Dr. C. E. Corrigan and Dr. Ross Cooper.

Clinical Laboratory Methods—Dr. Daniel Nicholson.

Diabetes—Dr. A. Hollenberg.

Infant Feeding—Dr. Gordon Chown.

Nephritis—Prof. Wm. Boyd. Dr. L. G. Bell.

Rectal Surgery—Dr. P. H. T. Thorlakson.

Dermatology—Dr. A. M. Davidson.

Goitre—Dr. Gordon Fahrni.

**Obstetrics:**

Pre and Post Natal Care—Dr. Blake Watson.

Mechanism of Labour—Dr. A. Blondal.

Face and Brow Presentations—Dr. W. G. Campbell.

Use and Abuse of Forceps—Dr. F. G. McGuinness.

Hæmorrhages of Pregnancy—Dr. C. L. Arthur.

Methods of Induction—Dr. A. S. Kobrinsky.

**Gynæcology:**

Radium and the Cautery in Cancer of the Cervix—Dr. J. D. McQueen.

Irregular Bleeding at the Menopause—Prof. D. S. MacKay.

The Friedman Pregnancy Test — Dr. Blake Watson.

Diagnosis and Treatment of Common Cervical Conditions—Dr. C. R. Rice.

Trichomonas Vaginalis—Dr. C. W. MacCharles.

Chest—Dr. D. L. Scott. Dr. M. B. Perrin.

Eye—Dr. T. Herbert Bell.

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## THE MAKING OF A WILL WHY — WHEN — HOW.

**WHY?** The answer to this question is essentially personal. If one is satisfied with the irreducible minimum, the law of intestate succession disposes of the matter quite simply. There are rules which in the absence of a will prescribe who shall inherit in accordance with their relationship to the deceased. At the end of the line, in default of all others, stands the government as the ultimate heir. But like all simple expedients applicable to human affairs, this statutory provision leaves much unsaid and is often quite inappropriate for the individual case.

In the first place, it appoints no executor — no one legally competent to take charge of the estate and deal with the many things which require immediate attention. Often months elapse before an administrator to fill the position is appointed by the court, and serious damage may occur meanwhile.

Secondly: There is no power to postpone conversion, and forced

sales are the rule. All well-drawn wills provide that the realization of the assets may be delayed until a satisfactory price can be secured. Sales on time may also be permitted.

Thirdly: There is possible only one type of distribution—payment to each adult heir in full as soon as the debts are paid, with the shares of minors tied up until they are of age. A will, on the other hand, may set forth the manner in which beneficiaries may receive their legacies. For example, the daily needs of the widow and children may be provided out of capital as well as income, in much the same manner as the husband and father would have done if alive.

There are many other matters which are dealt with in a properly drawn will, such as the funeral, succession duty, specific or pecuniary bequests and (what is becoming more and more common) even life insurance.

**WHEN?** The time for drawing a will is now. If there was any assurance of the continuance of any particular human life, there might be some excuse for pro-

crastination. A will is the most important document of a lifetime for by it is distributed all of the property of a deceased. A will once drawn may be altered, and should be revised from time to time. Very few wills drawn once and for all adequately express the well-considered wishes of the testator. The postponing of the making of a will until it is supposed that the hand of death is near, often leads to failure to make a will at all or the making of one which does not effectively carry out the wishes of the testator.

**HOW?** I have said that a will is a very important document. Like a major operation, it should not be committed to unskilled hands. No document has been so fruitful of unsatisfactory litigation as the home-drawn will. Such documents, though made with the best of intentions, often produce little but heartaches for their makers' dependents. A will should be drawn by a lawyer upon careful instructions, including all the information relative to the testator's affairs and those whom he wishes to benefit. There are often filial or marital irregularities upon which advice should be taken, for otherwise some of the testator's dearest dependents may be left without provision. There is, in fact, no limit to the care that should be taken to make sure that when "the moving finger—having writ moves on" there shall be no need for the wit of lawyers and the tears of widows to make a forlorn attempt at erasure.

To assist testators in this arduous task most well appointed trust companies have officers who may be freely consulted without any obligation. These officers are especially selected and trained to use the vast experience of the company to suggest the arrangements best calculated to carry out effectively the wishes of the testator, to save expense and reduce taxation. Adv.



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Vancouver General Hospital was held liable last year by the British Columbia Court of Appeal in a case which has just recently been reported in the Law Reports, where smallpox patients were admitted to a hospital indiscriminately with other patients. It was held that the failure by the hospital authorities to segregate the nurses attending the smallpox patients from the other patients and the failure to maintain a separate kitchen for the smallpox patients was conduct amounting to negligence, and a diphtheria patient who contracted smallpox obtained a judgment against the hospital.

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One of the outstanding features of DEXTRI-MALTOSE is that it is almost unanimously preferred as the carbohydrate in the management of infantile diarrhea.

In diarrhea, "The sugar is added gradually as conditions admit, some sugar other than milk sugar or cane sugar being used, preferably dextrin or dextrose."—H. E. Small: *Diarrhoea in bottle-feeding*, M. A. 12:152-158, Jan. 1932.

In diarrhea, "Carbohydrates, in the form of dextrin-maltose, well cooked cereals or rice, usually can be handled without trouble."—B. B. Jones: *A discussion of some of the commoner types of infantile diarrhea, and the principles of their diets used in their treatment*, Monthly, 55: 411-412, 1932.

"The most desirable sugar is dextrin-maltose because of all the sugars maltose is least apt to cause."—A. J. Blau: *The use of protein milk*, 119:359, April 2, 1932.

Concerning the treatment of diarrhea, "If the weight remains stationary, it is an indication that loss of substance is occurring through the stools. This loss of substance, the diet must be increased, mostly in the form of alkaline salts. To equalize this loss of substance, to avoid causing fermentation, but in such a way as to avoid causing fermentation. This may be done by adding dextrin-maltose and preparations of protein to the food. Increasing the calories until the infant is taking 160 calories per kilo, of body weight."—H. L. Ratnoff: *Nutritional disturbances*, Arch. Pediat., 41:771-772, Nov., 1924.

"... was the development of the science of being able to feed the infant with the use of proteolike protein milk, after only one day on a starvation diet, is apparent. In addition, the further advantage of being able to safely add a carbohydrate like Dextrin-Maltose No. 1 or No. 2 to the protein milk within a few days, enables one to gradually bring the infant up to its basal need to carbohydrate additions were advised. The result that many children on a starvation diet of collapse. The suggestion of Professor Finkelstein and the use of proteolike protein milk, was of great advantage. It is emphasized that adding carbohydrate to the stools, carbohydrate must be void collapse."—G. J. Feldstein: *Uncommon infants and children*, Arch. Pediat., 47:344-354, June, 1930.

In cases of malnutrition and indigestion, "The appetite improves rapidly, and the stools soon become normal in appearance, if the sugars are intelligently prescribed. By this I refer to proper proportions of dextrin and maltose. When there is a tendency to looseness, I have used the preparation known as 'Dextrin-Maltose' for the infants."—M. Ladd: *Further observations on the use of dextrin-maltose in the treatment of malnourished infants*, July, 1916.

"After the preliminary short period of starvation, protein milk should be used. . . . When the diarrhea has been sufficiently checked, dextrin-maltose may be added and gradually increased until from 4 to 6 tablespoons are being used."—W. L. Denney: *Acute nutritional disturbances of infancy*, Univ. West. Ontario M. J. 2:132-137, April, 1932.

Regarding the treatment of diarrhea, "In our experience, the most satisfactory carbohydrate for routine use is Mead's dextrin-maltose No. 1."—F. R. Taylor: *"Summer Complaints," Southern Med. & Surg.*, pp. 555-559, August, 1927.

In cases of diarrhea, "For the first day or so no sugar should be added to the milk. If the bowel movements improve carbohydrates may be added. This should be the one that is most easily assimilated, so dextrin-maltose is the carbohydrate of choice."—W. H. McCaslan: *Summer diarrheas of infants and young children*, J. M. A. Alabama, 1:278-282, Jan., 1932.

There is any tendency to sugar fermentation use a preparation with a high dextrin and relatively low maltose content, as Mead's dextrin-maltose.

"If it is desired to feed an unusually large amount of sugar to a baby, it is well to use a maltose-dextrin preparation, as in this way there is less danger of bringing about sugar fermentation than if lactose were used."—L. W. Hill: *Practical Infant Feeding*, W. B. Saunders Co., Phila., 1922, p. 206.

"The young baby, usually one-third milk and two-thirds maltose, usually skimmed at first, and a half ounce of maltose-dextrin preparation, as the carbohydrate. We prefer Dextrin-Maltose, as the carbohydrate most easily digested. . . . Preparations containing most easily digested. . . . Lactose which was very popular at one time, is never used in our work. The consensus of opinion seems to be that milk sugar is often a primary cause of fermentative dyspepsias in infants."—J. H. Reading, Jr.: *Artificial infant feeding*, 1923.

"Protein milk may be continued for several weeks when a gradual transition to a whole milk or one and one-half to two ounces of whole milk to one pound of body weight, is reached. This also amounts to five to seven per cent."—R. A. Strong: *Summer diarrheas in infancy and early childhood*, Arch. Pediat., 47:344-354, June, 1930.

"It should be remembered that a high percentage of lactose may cause diarrhoea. If a high percentage of sugar be required it is better to use dextrin-maltose, such as Mead's Nos. 1 or 2, where the maltose is only slightly in excess of the dextrin, thus diminishing the possibility of excessive fermentation."—W. J. Pearson: *Graduate Medical*, 6:38, 1930; 9:4, April, 1931.

"... I begin to add carbohydrates slowly, by replacing 1/4 ounce Casec every two days with 1/4 ounce of Dextrin-Maltose, preferably Dextrin-Maltose Number one. As a rule, this is tolerated. When one ounce of Dextrin-Maltose is used, the Casec, of course, should be discontinued."—J. W. Reed: *The etiology and treatment of infantile diarrhea*, 1925.

"When sugar causes diarrhoea one can change the form of it. Mead's Dextrin-maltose in small doses is more quickly absorbed and so superior to castor [cane] sugar. Lactose is expensive and seems not to be better than castor sugar."—H. B. Gladstone: *Infant Feeding and Nutrition*, 1925.

"Milk-sugar, which has been so extensively used in the past, should never be used where there is any digestive disturbance. It is not as easily digested as either cane-sugar (granulated sugar) or dextrin-maltose. The latter is the best of all sugars to use, especially if there is any tendency to looseness of the bowels."—A. Brown: *The Normal Child; Its Care and Feeding*, F. D. Goodchild Company, Toronto, 1923, p. 120.

For cases of fermentative diarrhea, ". . . the ideal plan of treatment would be to give a food of organisms thrive on (the food which that group of organisms thrive on) and high in protein. Calcium caseinate milk accomplishes this purpose. In our series of cases, we found it was necessary to use the casein calcium for from 5-8 days; we then stopped it and added dextrin-maltose to the formula."—A. G. DeSanctis and L. V. Paider: *The value of calcium caseinate milk in fermentative diarrhea*, Arch. Pediat., 47:344-354, June, 1930.

Just as DEXTRI-MALTOSE is a carbohydrate modifier of choice, so is CASEC (calcium caseinate) an accepted protein modifier. Casec is of special value during the summer months (1) for colic and loose green stools in breast-fed infants; (2) in fermentative diarrhea in bottle-fed infants; (3) as a prophylactic against diarrhea in infections.

mer months (1) for colic and loose green stools in breast-fed infants; (2) in fermentative diarrhea in bottle-fed infants; (3) as a prophylactic against diarrhea in infections.

When requesting samples of Dextrin-Maltose, please enclose professional card to cooperate in preventing their reaching unauthorized persons.

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